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## Original Communications.

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### Symptoms and Differential Diagnosis of Organic Heart Disease.\*

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Excluding para and peri-cardiac organic conditions, organic heart diseases are divided into two classes, structural and valvular. By structural is meant lesions of the muscular fibre, the connective tissue and blood vessels of the walls of the heart; by valvular is meant lesions of the valves, as a rule the connective tissue at the base of the valves, between their layers and at the circumference of the cardiac orifice.

Degenerative changes in the heart muscle, hyperplastic or proliferative changes in the connective tissue, and atheromatous changes in the blood vessels all diminish the power of the heart, and thus cripple its functions. Proliferative changes in the heart muscle increase its power and therefore augment its functional capacity.

Valvular lesions result in one of two things: First, stenosis, constriction or narrowing of the orifice, resulting in obstruction to the onward flow of the blood; second, incompetence, insufficiency or separation of the valve segments, resulting in regurgitation or a backward flow of the blood. The terms "stenosis, constriction"—"incompetence and insufficiency," express the organic conditions, while "obstruction"

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\*Read before the Jefferson County Medical Society.

and "regurgitation" express the functional alteration. The organic condition produces the functional alteration, and the functional alteration produces certain phenomena called "murmurs," which latter enable the diasnostician to locate and differentiate the location and variety of lesion. Therefore the terms "obstruction" and "regurgitation" are preferable terms for expressing the nature of the lesion—stenosis or incompetence.

The primary effect of all these valvular lesions is to increase the work of the heart. This, firstly, exhausts the normal reserve power of the heart; and, secondly, causes by normal physiological processes proliferation of the musculature of the heart, called hypertrophy. If this hypertrophy is equal to the increased work required under all bodily conditions there is adequate compensation, and, therefore, no symptoms. If there is no progress thereafter in the lesion, there will continue to be no symptoms. If, however, this compensating hypertrophy is inadequate, or if so under certain conditions, but fails under conditions of stress, or if there is progress in the lesion ultimately exhausting the proliferative power of the heart muscles, then there is broken compensation and symptoms appear.

The function of the heart is wholly dynamic. The left ventricle forces the blood forward in the systemic, and the right ventricle in the pulmonic circulation. The right and left auricles complete the filling and distend the right and left ventricles respectively. The accessory power of the left auricle is the right ventricle and for the right auricle the left ventricle.

When the power of any or all of the muscular walls of these cavities is not sufficient to force the blood onward there is passive hyperemia or venous congestion. This is true whether the primary lesion be degenerative changes in the walls of the heart without compensating hypertrophy, or in valvular diseases of the heart with, first, compensating hypertrophy, but afterwards broken compensation. The essential resultant pathologic condition, therefore, in both structural and valvular diseases with functional failure is diminished blood in the systemic arteries and increased blood in the systemic veins, and as a rule an increase of blood in both the arteries and veins of the pulmonic circulation. This latter, however, is modified by the site and variety of the valvular lesion, and is less marked in structural lesions.

The diagnosis of organic heart disease embraces the following points:

1. Whether the disease is structural or valvular or both, and if the latter which was primary.

2. In structural disease whether the lesion is muscle degeneration, and if so its form; whether there is connective tissue hyperplasia, or vascular changes, or all combined; in valvular disease the orifice or orifices of the heart, whether obstructive or regurgitant, or both, the degree of these, whether old or recent, whether stationary or progressive, and the degree and adequacy of the compensation.

#### THE DIFFERENTIATION OF STRUCTURAL AND VALVULAR LESIONS.

As the pathologic condition causing the symptoms in both of these is practically the same, to-wit, passive hyperemia or venous congestion, it follows that there is a marked similarity in those symptoms which are subjective; and as the organic lesions producing the venous congestion greatly differ it follows that there is a wide difference in the objective phenomena or physical signs. It is upon the latter that the diagnosis mainly rests. A full and comprehensive history of the case embracing all the points embraced in the anemnesis throws much light upon the case at hand. A personal and family history that reveals predisposing and exciting causes, and the clinical history of the case are all important.

The subjective symptoms of both structural and valvular lesions are mainly grouped as follows; the respiratory, the digestive, the dropsical and the cardio-vascular.

In both, one of the earliest symptoms is dyspnea, at first upon excessive exercise, or under any condition of stress. This recurs unless there is improvement, until there is orthorpnœa, loss of appetite, digestive disturbances—indigestion, eructations, constipation or diarrhea, frequently alternating, tympany, etc., etc. Early in the history of the case is dropsical effusion about the ankles and lower part of the legs. This, unless there is improvement, increases until the whole lower half of the body is dropsical, including genitals, more or less ascites, and possibly also effusion into pericardium and plurae. There is a feeling of oppression in the chest, more or less palpitation, sensations of cold-

ness and warmth often alternating, occasionally hyperesthesia or anesthesia in spots. The urine is usually scant, highly colored and high specific gravity.

### POINTS OF DIFFERENCE IN STRUCTURAL AND VALVULAR LESIONS.

In structural lesions the dyspnoea is less marked, more easily excited by exercise, is not so frequently relieved by appropriate treatment, and there is often palor instead of cyanosis; there is less dropsical manifestation, both in extent and amount, and as a rule, less severe but more constant digestive disturbances, and also the effect upon the secretion of urine is less marked. On the other hand there is greater prostration, weakness, general debility and nervous symptoms, syncopal, apoplectic, epileptic, etc. The response to treatment much less satisfactory and there is greater liability to sudden death and anginal symptoms much more common, often ending in death by an attack of angina vera.

There is a radical and marked difference in the physical signs, which I submit in parallel columns, to-wit:

#### VALVULAR DISEASE.

1. Enlargement of the heart structure from hypertrophy and dilatation.

2. Permanent murmurs, the primary obstructive or regurgitant; and transient murmurs due to relative insufficiency.

3. Apex beat displaced, and during compensation much more intense and larger area; in broken compensation the stroke is weakened, less distinct at one point and more diffuse.

4. When heart sounds are not substituted or marked by the mur-

#### STRUCTURAL DISEASE.

1. Heart not enlarged except towards the end slightly enlarged by dilatation, unless the changes are secondary to hypertrophy.

2. Permanent murmurs absent as a rule; transient murmurs due to relative insufficiency from dilatation—when present not so distinct and marked.

3. Apex beat in normal site, much weakened, and less area; in dilatation the beat very weak, larger in area, but not so large as in valvular disease.

4. Heart sounds less intense, shorter, second often lower in

murs, they are loud and distinct, pitch. They may be so feeble as often accentuated in pitch, particularly the second sound. to be almost inaudible.

5. Less tendency to arrhythmia, and changes in qualities of the pulse, except the changes characteristic, when present, of the lesion. 5. Arrhythmia almost constant, and decided alterations in the qualities of the pulse.

6. Enlargement of veins of chest and abdomen and lower extremities and lower rectum often present. 6. Rarely present and never so marked.

7. Venous pulsation, and augmented pulsation of arteries often present. 7. Venous pulsation rare and increased arterial pulsation never

8. Often enlargement of liver and spleen. 8. Rare and never so marked.

I shall not attempt a differentiation of the various forms of structural degeneration, but will merely enumerate the following:

1. Myocarditis usually follows peri or endo-carditis.  
2. Albuminoid degeneration or "cloudy swelling" is associated with or follows the essential fevers, notably those attended by high temperature or profound toxemia.

3. Cardiac fibrosis may follow myocarditis, endo- or peri-carditis or be associated with vascular changes in the heart muscle or with cirrhosis of the kidney or with general vascular sclerosis. Anginal symptoms common.

4. Fatty degeneration may follow the acute fevers, especially typhoid certain unusual forms, or, which is usually the case, with sclerotic and atheromatous conditions of the vessels of the heart. Anginal symptoms common.

5. Sclerotic and atheromatous changes usually associated with fibroid and fatty changes, or with aortic lesions, aortitis, or general vascular sclerosis.

From the foregoing it is apparent that the differentiation of the par-

ticular form of the structural change is very difficult, and that our chief reliance is upon the history of the case. (I note, in parenthesis that fatty infiltration, usually associated with obesity, may give rise to many of the symptoms of structural degeneration.)

#### DIFFERENTIATION OF VALVULAR LESIONS.

There are four orifices in the heart that may be affected by valvular disease, to-wit: the right and left auricle-ventricular, the aortic and pulmonic. Each of these may have one or both of two lesions, to-wit: stenosis and incompetence, causing obstruction or regurgitation to the blood current. Therefore there is a possibility of eight lesions, four stenotic or obstructive, and four incompetent or regurgitant. These are differentiated by studying three points, to-wit: 1. The relation of the murmur to the cycle of the hearts action; that is to say, whether it occurs with the contraction of the auricles, auricular systolic or ventricular pre-systolic; the contraction of the ventricles, or ventricular systolic; the diastole of the ventricles, or ventricular diastolic. They are generally designated as pre-systolic, systolic and diastolic, the terms refering to the movements of the ventricles only. Following the usual classification there are two pre-systolic, to-wit, mitral and tricuspid stenosis; four systolic, to-wit, mitral and tricuspid regurgitation, aortic and pulmonic obstruction: two diastolic, to-wit, aortic and pulmonic regurgitation. 2. The point of maximum intensity. This for the various lesions is as follows; mitral, the apex; aortic, the second interspace nearer the third rib and at edge of sternum on right side; tricuspid, near the left fourth cartilage near the sternum; pulmonic, third rib or third space near sternum on left side. 3. The duration of transmission, mitral obstruction toward sternum; mitral regurgitation, to the left and rear; aortic obstruction, upwards into carotids, aortic regurgitation, downwards toward end of sternum; tricuspid obstruction, downward toward ensiform; tricuspid regurgitation, upward into neck; pulmonic lesions not transmitted.

Of these eight lesions four of them are on the venous side, usually found in children and are congenital. Those on the left side are acquired and are the result of connective tissue changes in the valves following endo-carditis, as a rule, and are therefore acquired, and may be developed at any age, but very rare in infancy and rare in childhood.

The differential diagnosis of the lesions on the left side is as follows:

1. Mitral obstruction, murmur pre-systolic, loudest at apex transmitted toward sternum—often accompanied by a thrill.

2. Mitral regurgitation, murmur systolic, loudest at apex and transmitted to the left and rear.

3. Aortic obstruction, systolic, loudest right second interspace at edge of sternum transmitted into carotids.

4. Aortic regurgitation, diastolic, loudest at second right interspace at edge of sternum and transmitted downward toward ensiform.

In all of these their respective relation to the heart's cycle is constant; the point of maximum intensity may vary slightly, and there may be little or no transmission.

Hypertrophy is a constant condition, and develops as follows; mitral obstruction, left auricle, right ventricle, right auricle and perhaps later the left ventricle; mitral regurgitation, left auricle and left ventricle, probably simultaneously, right ventricle and right auricle; aortic obstruction, where there is adequate compensation and no mitral regurgitation, the hypertrophy is confined to the left ventricle, but in the event of opposite conditions then the left auricle, right ventricle and right auricle; aortic regurgitation, when the compensation is adequate and no mitral regurgitation, the hypertrophy is confined to the left ventricle, and in opposite conditions the hypertrophy is in the same order as in aortic obstruction. Generally speaking in cases that run a progressive course there is hypertrophy more or less of entire heart. In all ventricular hypertrophies the apex is upwards the left—that of the left ventricle downwards, and of the right horizontally or slightly upward.

The diagnosis of cardiac hypertrophy, under ordinary conditions, is easy. The displacement, increased intensity and larger area of the apex beat, or rather, systolic impact, the increased area of actual flatness, of dullness and relative dullness, easily demonstrate it; and the presence of intrinsic or extrinsic causes of hypertrophy complete the evidence. It may be confounded with dilatation; but the difference in the intensity, area and quality of the apex beat, and the presence of the usually definite symptoms of broken compensation easily differentiate dilatation. In pulmonary emphysema, which may be the extrinsic cause of hypertrophy of the right ventricle and possibly right auricle and it may be left ventricle, the emphysematous lung may cover the

entire heart, push down the diaphragm and with it the organs, in the upper zone of the abdomen, thus altering the normal relations of adjacent organs with their normal physical phenomena, a mistake may occur. In such cases the diagnosis of these altered relations is a prerequisite to the diagnosis of cardiac hypertrophy. After this strong, forcible percussion with firm pressure of the pleximeter in an interspace will bring out a larger area of cardiac dullness. The apex of the heart may be displaced from other causes, thoracic and abdominal, pushed out or pulled out. Here again it is absolutely necessary to diagnose these conditions, when the cause of the displaced heart will be shown, after which the heart may often be outlined by percussion showing that it is normal in size.

The extrinsic signs of valvular lesions are of great importance. The behavior of the pulse is often very significant. In mitral obstruction the slow and imperfect diastole of the aorta and arteries, the power between their diastole and retro-active systole and the brevity, slowness and shortness of the latter make a sphygmographic tracing quite characteristic. The pulse appears weak and small to the touch. In aortic regurgitation the quick and great diastole of the aorta and arteries, the quick start and rapid consummation of their systole make a tracing that is pathognomonic. The pulse is strong, large and full, and suddenly drops beneath the finger. This is the so-called Corrigan and water-hammer pulse. The increased pulsation in all the arteries and the so-called capillary pulse are also present in aortic regurgitation.

The slow but rather complete diastole of the aorta and arteries in aortic obstruction is quite characteristic. The artery is felt to gradually fill under the finger. If there is anything particularly suggestive in the pulse in mitral regurgitation it is its altered rhythm, particularly as to regularity. The enlargement of the thoracic and abdominal veins, and of the liver are particularly constant in lesions of the right side of the heart, and therefore in congenital lesions. They may be also present in lesions of the left side, but they are more constant in lesions of the right side. The broken compensation in the hypertrophy of the right ventricle from pulmonary emphysema and fibroids, the presence of tumors, etc., are often present. In mitral obstruction there is often hemoptysis and in aortic lesions particularly regurgitant anginal symptoms are frequently present.

The degree of valvular lesion, whether stationary or progressive, and the adequacy of compensation are of greater importance than the valves affected, or whether obstructive or regurgitant. It is true that authors classify the valves and lesions as to their gravity, probably of progress, etc., and it is also true that they differ in this. I shall confine what I have to say to the symptoms and sign phenomena which throw light upon these points.

#### QUALITY OF THE MURMURS.

A cardiac murmur like all other sounds has its intensity, dullness, pitch and quality. Differences in these are found in heart murmurs. Authors have undertaken to indicate the degree of the lesions by certain characteristics of the murmurs in their intensity, duration, pitch and quality. In my opinion they have not succeeded. In any given case of valvular disease of the heart in which there is adequate compensation, there is a murmur of rather fixed properties. These may be modified by conditions of rest, activity and severe exertion, but are constant under these conditions. This signifies a stationary lesion and adequate hypertrophy. Changes in these properties under the same conditions of rest, activity and severe exertion show progress of the lesion or inadequate compensation. In my judgment, therefore, it is not so **much** the properties of a given murmur as the presence or changeableness of these that signify the condition of the lesion and the compensation. Indeed there may be a murmur due to roughening of the valves without either obstruction or regurgitation, and these are sometimes the loudest and most distinct murmurs heard. Change from character what appear to be the constant qualities of the murmur under the heart conditions are very important. The development of new murmurs under the heart conditions are very important. The development of new murmurs permanent or transient is also of great importance. Finally the disappearance of murmurs altogether may show the approaching dissolution.

Duration of lesions. This is of great importance. If it has lasted a long time and there are no symptoms under the ordinary circumstances of life's acclimate the presumption is stationary lesion and adequate compensation, and that such will continue to exist.

Early progress of lesion. If this is rapid there is not, *pari passu*, hy-

pertrophy, and therefore the symptoms of imperfect circulation, and death may result early.

Duration and frequency of attacks of broken compensation. Frequent attacks of broken compensation, often full compensation show progress of lesion. Increased duration of these attacks shows progress of lesion and the failure of progressive compensation.

Effects of treatment. Failure or marked slowness to respond to treatment indicate progress of lesion or failure to compensate.

These in my judgment are far more important criteria of the degree and progress of the lesion and the presence and possible acquisition of compensating hypertrophy than the qualities of the murmur.

Generally speaking, the degree and progress of the degenerative structural changes can only be arrived at by the careful study of the symptoms and signs in the course of the case.

I have not alluded in this paper to concentric hypertrophy, or the hypertrophy the result of causes outside of the heart. The diagnosis of this type of hypertrophy is easy. The increased area of cardiac dullness; never so great as in the excentric variety, the increased intensity and area of the apex beat, and the accentuation of the aortic second sound, and the absence of murmurs showing valvular disease, are the points in the diagnosis. When this compensation is broken the same symptoms as in valvular disease are developed, and in addition systolic murmurs indicating relative incompetence of the auriculo-ventricular valves may develop, disappearing with restoration of compensation, or in the weak action of the heart in fatal cases.

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### **Cholelithiasis—Diagnosis and Medical Treatment.\***

*By T. L. Robertson, M. D.,*

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Cholelithiasis is a condition of the biliary secretions which tend to form concretions in the gall bladder and biliary ducts. So long as these concretions, or gall stones, remain quiescent in the gall bladder they do not as a rule give inconvenience, and may indefinitely exist unsuspected, unless they become sufficiently abundant to cause painful dis-

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\*Read before the Jefferson County Medical Society.

tention, but their migratory tendency into the bile ducts, usually sooner or later stirs up trouble. Biliary colic is characterized by a sudden onset, accompanied by severe pains in the right hypochondriac region, radiating to the shoulder, and may be very intense in the epigastric and lower thoracic region. There may be rigor and rise of temperature. The pain is agonizing, and often attended with vomiting, profuse perspiration, and general depression. The attack varies in duration from a few hours to several days, or a week or more, depending upon the shifting of the stone to a position where it does not give pain—usually into the gall bladder, or, if in the common duct, it may escape into the duodenum and be discharged through the alimentary canal.

Jaundice develops in a large number of cases, but is by no means a constant symptom. Of course it does not occur during the passage of the stone through the cystic duct, but only during its passage through, or when lodged in, the common duct. Most frequently the jaundice is transient, but should the stone become impacted in the common duct the jaundice becomes intense.

The attacks may occur at intervals of a few days, or weeks, until the stones become dislodged from the ducts, when the symptoms will rapidly clear up, and the patient's condition will assume the normal.

The severe pain is due to the necessary distention during the slow passage of the stone through the acutely inflamed bile ducts. There is a form of cholangitis which presents symptoms very similar to those produced by gall stones, and not easily differentiated from them. Surgeons have not infrequently performed cholecystotomy in such cases believing stones to be present. The pain in the upper abdominal and thoracic region differentiates gall stone colic from nephritic colic, which refers the pain to the lower abdominal region, radiating from one or both kidneys along the course of the ureters.

Early in an attack of appendicitis or obstruction of the bowels the pains may simulate those of biliary colic, and are not readily differentiated, but after a short waiting the pains are usually located at the site of the trouble, and most of the difficulty is cleared away.

The symptoms of gastralgia are sometimes confounded with those of biliary colic, but those of biliary colic are more frequently attended with chill and fever. The history of previous attacks is an important

guide, and the development of jaundice, however slight, determines the diagnosis.

In obstruction of the cystic duct we have a distended gall bladder, and in acute cases the contents are bile mixed with mucous and purulent matter. In chronic cases the bladder may be distended to large size, the contents in these cases are usually a clear mucous. Distention of the gall bladder often occurs without jaundice; it is said by some authorities that the greatest enlargements have occurred in such cases.

Gall stone crepitus may be felt when the gall bladder is well filled with stones; especially if the abdominal walls are relaxed and not too thick, and they may be found in patients who have never had symptoms of cholelithiasis.

Emphyema of the gall bladder is not an uncommon condition; often containing large quantities of pus, the infection superinduced by gall-stone irritation. Perforation with fatal peritonitis is a contingent accident; also abscess formations in the neighborhood of the gall bladder due to leakage. It is not unusual for calcification or atrophy of the gall bladder to follow these conditions.

Obstruction of the common duct produces quite a different line of symptoms. It is usually due to a lodgement of one or more stones in its tract, sometimes extending into the hepatic duct, in these conditions the jaundice is deep and enduring and may persist periodically for months or even years. In cases accompanied by infection chills with high fever are frequent as in other septic conditions.

Intense itching is a very troublesome and not infrequent symptom and may prevail during the existence of the diseased condition.

In obstruction of the common duct the gall bladder is rarely distended. There are many remote effects of gall stones which produce symptoms which should be considered in making up a complete diagnosis, which I will not attempt to discuss, but rather leave them to the consideration of those who may feel inclined to discuss the subject.

The medical treatment of these cases though limited is supremely important. The greatest boon to our patients is the relief of pain, and in no condition are the appeals greater than in this one. Hypodermics of morphine in sufficiently large doses and at sufficiently frequent intervals seem to meet the ends best. Should the morphine be a little slow in subduing the pain, a few whiffs of chloroform may be given.

The morphine in these cases not only relieves the pain, but relaxes the spasmodic condition and promotes the passage of the stone to parts less objectionable.

The soda salts, such as the sulphate and the phosphate, in doses sufficiently large and at sufficient intervals to produce a laxative effect may be given. It is claimed that these salts tend to liquify the biliary secretion and inhibit concretions. Olive oil has had its day, ether and turpentine in equal parts have their advocates, but are regarded with little favor now. Hot stupes or hot poultices have a soothing effect and are not to be condemned. The extreme itching is best relieved by dusting powders and soothing lotions.

In recent years much progress has been made by surgeons especially in this field. Cholecystotomy is now considered an operation attended with few dangers in the hands of skillful surgeons. Therefore when we have gall stone cases with frequently repeated attacks we will do credit to ourselves and justice to our patients by referring them to a competent surgeon.

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### **Intravenous Injections of Mercury In Syphilis.**

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In probably no other disease does the rapidity of the result of the treatment count for more than it does in syphilis. This is specially true when delicate structures are involved threatening the loss of sight, hearing, etc., or where violent ulcerations promise disfigurement and unremediable destruction, and even, in the earliest stages, a quick control is a safe guard against the infection of others. The ideal treatment is one that is positive in its results, free from pain and danger, and non-interfering with home and business life. In the method of administering mercury intravenously, the medical profession has a procedure which comes nearer to fulfilling all these qualifications than any other known way of administering this valuable drug. It alone, where active syphilis is the prime factor to be considered, will accomplish results in a shorter time than can be produced by any other known treatment or at any place. Like any other therapeutic measure with exceptional merits, it presents certain drawbacks, it cannot

be used in cases where it is impossible to make the veins sufficiently prominent so they at least can be found by rolling them under the skin, and besides, its successful manipulation might be difficult for some to master.

The best criterion to the value of any treatment is the citation of results in cases representing various stages of the disease and presented under different surroundings, circumstances and conditions.

Case 1. Syphilitic Chancre.—Mr. —, age 29 years. Noticed slight genital sore about two weeks after exposure. This was carefully examined at stated intervals until the sore was about three-eighth inch in diameter and showed a typical parchment induration. The chancre had by this time nearly reached its maturity and probably would have disappeared naturally in a period of from four to six weeks longer. The sore being characteristic, a diagnosis of syphilis was made without awaiting secondary manifestations and the patient was placed upon the bichloride of mercury intravenously. He received fifteen injections each dose averaging 0.0124 grams (1-5 grain). After the ninth day, the sore with the induration had entirely disappeared.

This shows the quick influence that this form of treatment has over the primary sore—a matter of great importance in many cases, especially if such cases are a source of danger to others. Besides this, such a quick reduction of a sore might be of great diagnostic value, for ordinarily a chancre resolves rather slowly under the usual mercurial medication.

Case 2. Secondary macular eruption, very profuse over body, extremities and forehead, mucous patches in mouth and around anus, beginning alopecia and marked adenopathy.

Mr. —, age 30 years. This patient contracted the initial sore some eight or ten weeks previously. Throughout the last three weeks of this period he had been on a spree during which time all the early secondary manifestations developed luxuriantly. He was placed upon the intravenous injections of the bichlorid of mercury, receiving twenty injections averaging 0.016 grams (1-4 grain) to each dose. After the tenth injection all the secondary symptoms excepting the glandular enlargement had disappeared; the hair, however, showed a slight moth

eaten appearance, but all further shedding of same had ceased. After the twentieth injection, most of the enlarged glands had been reduced, a few could still be felt.

As a rule an ordinarily well developed secondary eruption will disappear in from twenty to forty days under the usual form of treatment. In the above case the secondary eruption was especially severe, covering practically the entire body and extremities, his dissipation undoubtedly assisted in this development. The eruption showed itself in its ascendancy, therefore, the normal fading which occurs in all cases after a lapse of time, was not a factor to assist in the obtaining of quick results in this case.

Case 3. Syphilitic ulceration of the throat, having destroyed the uvulæ, posterior part of soft palate and the anterior pillars,

Mr. ———, age 24 years. Contracted syphilis eighteen months previously, during this period did not adhere to a strict treatment. The above mentioned ulceration had existed for about six weeks and had resisted all treatment, spreading with great rapidity. Fifteen injections of the bichloride of mercury given intravenously cured the lesion. The dose averaged 0.013 grams (1-5 grain) daily.

Case 4. Ulcerating syphilitic paronychia of both little fingers and the thumb.

Mr. ———, age 35 years. Contracted syphilis two and one-half years previously. Received three weeks inunction treatment at the start and then was put upon a mixture of mercury and iodine which he took up to the time of first consulting me. At this time he presented an eruption over the entire body. This was diagnosed as an iodine eruption and he was advised to discontinue the use of this drug, the result was that the eruption soon disappeared. One month after this he developed an acute attack of jaundice which was overcome without the use of antisymphilitic remedies. Three months after stopping his antiluetic treatment, he developed the above mentioned paronychia. This case was placed upon the intravenous injections of mercury, receiving 18

injections, each averaging 0.016 grams (1-4 grain). After the sixth injections all active ulceration had ceased and pus could not be squeezed from the region of the matrix or from under the nail. After the twelfth injection, complete healing had taken place and but a red and slightly elevated ridge showed the site of the past inflammation. No iodine was given in this case because of the previous poisoning by this drug.

Case 5. Syphilitic ecthyma taking on a rupial character, of right arm. Ulceration about one inch in diameter.

Mr. ———. Contracted syphilis between four and five years previously. Treated by internal medication and inunctions of mercury for over three years. The above mentioned ulceration had existed for about two months. This case was given the daily intravenous injections of the sublimate, each dose averaging 0.020 grams (1-3 grain). The ulceration was perfectly healed by fifteen treatments.

Case 6. Syphilitic ecthyma of face and neck, showing five violent ulcerations of these parts.

Mr. ———, age 27 years. Contracted lues seven years previously. Treatment was fractional and indifferent up to the time the above lesions became manifest, when a course of mercurial inunctions with iodine internally was diligently adhered to with the result of but a very slight improvement. He was placed upon the intravenous injections of mercury, receiving 22 injections, each averaging 0.013 grams (1-5 grain). All the ulcerations were healed by the twenty-second day.

Cases 3, 4, 5 and 6, show conclusively what can be accomplished by this form of treatment in severe ulcerative lesions not preceded by a gummatous infiltration.

Cases 3, 4, 5 and 6, show conclusively what can be accomplished by size 1 3-4 by 1 inch, on outer surface of left leg. Another gumma, 3-4 inch in diameter on inner surface of lower third of right thigh.

Mr. ———. Contracted syphilis 4 1-2 years previously. Treated for first four months by inunctions, followed by internal treatment

until the end of the second year when four months were spent at Hot Springs, Ark. During the third and fourth years alternated on some vegetable compound and the protiodid of mercury. At the time of consulting me, he showed the above mentioned symptoms which had been advancing in spite of the treatment. This case was given the intravenous injections of the sublimate, receiving eighteen injections in nineteen days, each dose averaging 0.020 grams (1-3 grain). After the fourteenth injection the small gumma of the thigh had entirely disappeared, after the nineteenth, the large gumma of the leg had been completely reduced, leaving but a small abrasion of the skin which healed without further treatment. No iodine was given.

The above case shows what can be accomplished by intravenous mercurial medication without the assistance of iodine, in typical non-ulcerating gummatous lesions. Statistics of other cases with typical gummata which have not ulcerated, show that this syphilitic manifestation can be controlled and eliminated on an average of from 18 to 25 days by the intravenous use of mercury alone; if iodine is added to this treatment the case will ordinarily show a gain of a few days. The peculiar feature of a non-ulcerating gumma is, that it does not respond as readily to a mercurial treatment as does the gumma which shows marked ulceration and has but little purely gummatous tissue remaining. This may be accounted for theoretically, in that the unbroken or very slightly ulcerated gumma must depend for its absorption upon the slow reconstruction of the circulation, while the broken gumma is easily separated from the surrounding syphilized but vital area. The next case upholds the later part of this theory.

Case 8. Ulcerating syphilitic gumma about the size of a walnut, situated immediately in front of the left ear, involving the tragus, lower and anterior part of the helix and upper portion of the lobule. The ulcerated surface extended over the anterior wall of the external meatus and lapped over the tragus. The same structures of the right side were involved only the mass was about one-fifth as large as the other and the ulceration considerably smaller. Besides this, there was a large mass about half the size of a bantam's egg, one inch below the left ear, this was either a large gumma or a mass of adherent glands.

Mr. ———, age 28 years. Had genital sores 2 1-2 years and 1 year previously, took internal treatment for a short period at each occurrence. The lack of definite information, leaves undecided the time he contracted syphilis. Two months before consulting me, he noticed the beginning of the above mentioned condition. During part of these two months, he received anti-luetic treatment, but it had no influence over his lesions. This case was given the intravenous injections of the bichlorid of mercury, receiving 16 injections in 21 days, each dose averaging 0.010 grams (1-6 grain. After the fifth injection, the gummatous mass with the destroyed overlying skin seemed to loosen from its bed and with a pair of forceps large portions were torn away. After the eighth injection all ulcerated and dead tissue had separated, carrying with it a portion of the tragus, leaving a healthy granulating cavity nearly one inch in diameter and three-fourths of an inch deep. The swelling under the ear had decreased by one-half, while all the swelling in the right ear had disappeared. After the tenth injection a moderately severe gingivitis developed and the patient was given 2 grams of potassium iodid a day. An examination of the teeth showed them to be in very poor condition. The small doses in this case were prompted by the exceedingly low weight of the patient and by the quick reaction upon the gums; the doses, however, were sufficiently large for a speedy and absolute control of the cases. After the fifteenth day the wound had granulated even with the surface and was practically healed a week later. The iodine was discontinued after one week's use.

This case demonstrated the complete "throwing off" of gummatous tissue which has been partly undermined by necrosis. Recent experiments have shown that inoculations with broken down tissue from gummata or other late lesions are negative, but that positive inoculations can be made when the inoculating material is taken from beyond the necrosed area. From this it may be reasonable to suppose that the devitalized tissues are free from active syphilis, but that in the immediate surrounding vital area the agent of syphilis is thriving and active; therefore, the intense and exceedingly rapid action of mercury obtained by giving this drug intravenously, so speedily overcomes active

syphilis in this surrounding vital area that an adhering mass of far lesser vitality and practically dead from malnutrition and secondary germ infection, is enucleated by a clean cut line of demarcation.

Case 9. Ulceration due to a partial destruction of a gumma, 2 by 1 1-2 inches in diameter. Location, upper portion of right calf. Two minor ulcerations in immediate vicinity from a similar cause.

Mr. ———, age 27 years. Contracted syphilis five years previously. Adhered to internal treatment for about two years, after which all medication was stopped. Gumma first noticed three months before consulting me. This patient was inclined to dissipate and paid but little attention to his condition until the size of the ulceration became alarming and an interference to his routine pleasure. He was given the intravenous injections of the sublimate, receiving 20 treatments, each dose averaging 0.016 grams (1-4 grain). Throughout this course he was given all the so-called natural advantages at Hot Springs, Ark., and to grant him full satisfaction in accordance to the routine of the place he was also given the iodid of potassium internally, 3 grams (45 grains) per day. After the tenth injection, all ulcerations were granulating nicely and by the twentieth were healed.

Although this case received moderate doses of iodid and the advantage of baths, etc., results were not obtained any faster than if mercury had been given alone and under home conditions. My statistics cited in a recent article\* fully substantiate this statement.

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\*Chicago Medical Recorder, October, 1906.

Case 10. Ulcerating gumma of left shin.

Mr. ———, age 48 years. No definite history obtainable. Was placed upon the intravenous injections of the bichlorid of mercury, receiving 21 injections, each averaging 0.013 grams (1-5 grain), also upon potassium iodid in ascending doses up to 8.32 grams (125 grains) three times a day. Throughout this course he received all the advantages of the baths, etc., at Hot Springs. The wound was practically healed in 23 days.

This case shows that even with the assistance of large doses of iodid, no more rapid improvement was obtained than if the mercury had been used alone.

Cases 7, 8, 9 and 10fi are fair examples of what the intravenous injections of mercury, alone or assisted, will accomplish in gummata or ulcerations following same.

Case 11. Syphilitic iritis of the right eye, showing marked conjunctival inflammation and chemosis, great ciliary congestion, cornea dull, iris level and slightly faded, pupil contracted and limited in motion and several posterior synechiæ. Very severe pain especially at night.

Mr. ———, age 50 years. Contracted lues about six months previously. During the last two months of this period had moderate inflammation of the right eye which developed very markedly during the last two or three weeks, at the expiration of which time he presented the above conditions. The diagnosis was made and the local eye treatment was conducted by Dr. H. W. Allport of this city, to whom I am indebted for the report of exact conditions. This patient was placed upon the endovenous injections of the sublimate of mercury, receiving 18 injections in 20 days, each dose averaging 0.019 grams (1-3 grain). After the fourth injection, all pain ceased, after the eighth injection the eye was practically normal and could be used without inconvenience.

In a previous publication,\* I made a statement to the effect that the endovenous injections of the bichlorid of mercury exerted a most marked beneficial influence over syphilitic inflammations of the eye, an influence which cannot be as readily obtained under any other known treatment.

Case 12. Syphilitic pachymeningitis manifested by moderate headache and neuralgia, thick speech, depreciation of mental power, in-

\*Chicago Medical Recorder, April, 1906.

somnia, vertigo, and rather sluggish and inaccurate movements; besides this, there was a consolidation of the upper portion of the right lung.

Mr. ———, age 37 years, Contracted syphilis four years previous-

ly. Adhered to internal treatment for about 2 1-2 years. The above condition developed slowly, so its first appearance was unnoticed; well developed symptoms had been present for about one month. This patient was given the bichlorid of mercury intravenously and moderate doses of potassium iodid per month. He received 22 injections averaging 0.013 grams (1-5 grain). After the fifteenth treatment, no lung consolidation could be found. After the twentieth injection all other symptoms had disappeared, doing so completely inside of ten days longer. This patient was told to continue some antiluetic treatment, but neglected to do so. About sixteen months after completing this first course, he developed a partial ptosis of the left eye lid. For this condition he took a course of the intramuscular injections of mercury with moderately large doses of iodid internally, this course was given by another physician. The treatment evidently was not of sufficient intensity, for the results were not satisfactory. The case again came under my care about ten months after the appearance of the ptosis. He was given another course of the intravenous injections of mercury, receiving eighteen injections, each averaging 0.013 grams (1-5 grain), in conjunction with this he was given 2 grams of iodid-nucleoid a day. At the end of the course the dropping of the eye lid was practically nil. There was, however, a retardation of motion when glancing quickly upward, during deliberate motion, but little difference was noted.

Cases of paralysis, locomotor ataxia and paresis, will not be cited in this article, yet I wish to state that if in such cases active syphilis is still a concomitant factor to be considered, no other known treatment will show this as quickly as the intravenous injections of mercury, assisted in occasional cases, by the judicious use of iodin. If these so-called para-syphilitic cases are taken in their very incipiency, excellent results can be expected from this form of treatment. The above cases, which were taken as fair average examples, show conclusively what can be expected from an intravenous mercurial medication when active syphilis is the factor to be overcome. These cases were chosen for this report, as they showed a rather distinct division; however, the same ideal results can be obtained in cases presenting a greater variety of lesions or more complex symptoms.

42 Madison Street.

## Correspondence.

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FROM DR. W. T. BERRY.

New York, August 10, 1907.

My Dear Doctor Bell:

You asked me before I left Birmingham to let you hear from me during my stay in New York city. There are many things of great interest going on here in a medical and surgical way. The medical profession is certainly keeping abreast with the immense progress being made here in other lines. Many of my friends with whom I was associated for two years in hospital work five years ago are located in New York and take pleasure in helping me to see the best that is going on in our profession. New York is without a doubt the great "medical Mecca," and the clinics at the different hospitals are always well attended by visiting physician from all over the United States and Canada. A stranger in our profession who is not personally acquainted with the big men, or at least a few of them, of course feels lost and lonely, but he can soon catch on to the ways and means of securing the best that's going.

At the "Roosevelt Hospital" is a young Birmingham boy who is now acting house surgeon on the first surgical division. Drs. George Brewer and Chas. H. Peck are the attending surgeons. I refer to Dr. Earl Drennen, who is now finishing up at the "Roosevelt Hospital." I am pleased to acknowledge my obligations to him for the many personal courtesies he is now extending me by permitting me to not only attend the public clinics but also to be present at the private operations of Drs. Jos. Blake, L. W. Hotchkiss and George Brewer. I was quite interested yesterday at the clinic there to find Drs. Brewer and Peck using "rectal anesthesia" with the greatest possible success. Dr. Peck tells me that he starts the patient with "ether" and in a few moments removes the cone from the face, inserts an ordinary rubber tube four to six inches up the rectum, and by means of an ordinary bulb (hand) syringe attached to the other end of the tube pumps ether into the rectum. The operation is a simple thing. It has a return tube also which lets the gas escape from the rectum. I saw Dr. Peck do a "thyroidectomy," a "laparotomy," an operation for "undescended tes-

ticle," and wire a "fractured femur," employing nothing but the "rectal anesthesia." I never have seen patients do better than they did—no bronchial irritation or congestion, no vomiting, no unpleasant symptoms in the least. Dr. Peck says also that no "proctitis" ever follows the use of the "rectal tube." Altogether he thinks this way of anesthetizing a patient is a marvelous improvement over the old method, especially when it comes to operations on the head or neck and when you wish to avoid any bad after effects of your anesthesia.

Drs. A. T. Bull and Wm. B. Coley at the Hospital for the Ruptured and Crippled are still doing a very large amount of "hernia work" there. Dr. Coley reports two thousand cases of "herniotomy" having been done by him at the Hospital for Ruptured and Crippled within the last seventeen years. He does the "Basini," but does not transplant the cord or round ligament any longer as he used to do. His posted report on the wall of the operating room shows that out of that large number of operations he has had but thirteen recurrences or .65 per cent. All kinds of hernia work is being done there—ventral, epigastric, umbilical, inguinal, femoral. It is a marvel to see these fellows work. All cases under fifteen years of age are put up in plaster-paris.

Dr. Gibson of St. Luke's Hospital is doing a great work. His clinic material is abundant and he is doing a large number of "prostatectomies" by the perineal route. I suspect he is doing as many "prostate operations" as any man in New York at present.

"The German," "the Presbyterian," "the New York," "the Mt. Sinai" hospitals are all working at full tilt and afford the visiting physicians many profitable clinics.

I cannot close without mentioning the kindness of Dr. Folber Cabot to me. He is doing a great deal of "prostate work" also and affords me the privilege of being with him in his cases.

Dr. Royal Whitman is doing an immense amount of bone and joint surgery at the Hospital for Ruptured and Crippled. From twelve to fourteen bone or joint operations are done at every clinic. Drs. Gibney and Whitman having been my preceptors in this line of work five years ago while I was serving on the staff there naturally take enough interest in me to allow me unlimited privileges at their clinics.

There are many other things in a medical way of interest going on, but I will not say anything further just now. I verily believe New

York city is the best place you can find to get what you want, and not get just one man's idea about doing a thing.

Yours very truly,

W. T. Berry, M.D.

318 West 57th St., New York City.

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FROM DR. BROWN.

Atlantic City, N. J., Aug. 5, 1907.

Editor Alabama Medical Journal

Dear Sir:—Your Journal for July containing your rebuttal of my argument in the June number has just reached me, and altho the sea air, time and distance have taken most of the fight out of me, I must beg your further patience while I say a few words to your charge that I have long nursed a personal grievance. The evidence of this to you must lie in a deep sub-consciousness that I have grounds for one; because with the exception of this time, when I used it solely to answer your assertion that "no one ever failed to get a hearing," I have never written a word about it nor spoken of it in meeting. On the other hand I have always paid my counsellor's dues, attended all the meetings and read a paper at each one which must be credited to me as at least well and cheerfully intended. I assure you I only brought it up this time as an example that a resolution could not always be heard. By being heard I meant being heard by the Association. You perhaps meant being heard in Committee. In this case, however, I was not even heard in Committee, but you perhaps had forgotten that. I still think it very unfair that a resolution offered in good faith that it will be brought up in regular order at the next meeting should be killed in that arbitrary way in committee and the drawer of the resolution not even notified of their action which is sprung an intentional and complete surprise at the moment he attempts to call it up for discussion. The only use I have had for the Brown resolution since then was in the present case, to illustrate the point I made, i. e., that free discussion is not possible (on some measures at least) until the committee has passed on it. If this legislative trick has been adopted as a means to facilitate business and 'scotch' offensive cranks I have no further quarrel with it. I repeat that I used it solely for illustration and that no member of

the association is freer from nursing a personal grievance against it than I am. If I was invited a year later than the legitimate time (which I do not recall at all) to relieve my surcharged feelings of my bottled up remarks, there could be several reasons why I did not make a stirring speech on the subject. Can't you imagine for instance how the very arrogance and absurdity of such an offer could render one speechless? No one had the right to offer me the privilege of the floor to discuss a resolution that had been dead a year. Had I attempted it fifty should have called me to order and others should have led us both off in custody for trifling with the meeting. Such an offer was out of order, illegal, arbitrary, irrelevant and illegitimate, and the occasion cold and dead. Withal it was so unexpected as to be not at all generous, but I don't doubt it had a purpose. If I was offered this brilliant opportunity its very absurdity would have caused it naturally to make little impression on my mind. I am sure our constitution says a resolution is to lie over one year, not two. I don't think a lover would want anything better than the chance to delay his rival's letters in the postoffice a year.

I am not nursing a grievance but a few opinions too robust to need nursing have settled down with me I'll admit. I still believe free discussion, universal suffrage and majority rule are good things and I am afraid I always shall. Also I believe all members of our Association should be illegible to office. Also I believe that what indifference is shown by the visitor members we counsellors are directly responsible for. I shall always believe in working toward elevating our standard of examinations to the end of one day having reciprocity in the recognition of certificates to practice with all the best state boards.

Finally, Mr. Editor, try to disabuse your mind of the fear that any one is trying to tear down the Association. You may believe that certain policies of others if carried out would tear it down, but give them the credit of being honest. No one in our Association, in my belief, believes his own policies would do aught but benefit the Association. Some think the present plan if it persists long enough would result in dry rot or auto-intoxication. They may be right or wrong and still honest about it. I do you that justice. When you launched your gloomy prophecy about what the trouble makers were proposing to do down in Mobile and started all this breezy correspondence, I know you were

honest in your fears (though they really didn't try to do anything, did they?); and I know now that you were tired and had you been up here things would have looked rosier and with this perspective, instead of a mob of trouble makers, ignorant of the laws and the prophets, you would have seen only a throng of earnest minded doctors moving on Mobile, nineteen twentieths of whom didn't give a dime for your politics and machinery, but were gleefully anticipating relaxing with old friends and justifying their holiday with the prospect of learning something from the papers and discussions that would benefit some poor old patients when they get back. You really should not make light of those papers and discussions--they will always be more important than your machinery.

You see this idleness and sea air has taken all the fight out of me and writing to and about you busy fellows down there has made me homesick and envious so that I want, finally, to get well and get back to work. I can even calmly contemplate living in perfect harmony with all of you for say three months at least, with never a scrap, busy in our common cause against ignorance, disease and death.

Very sincerely,

G. S. Brown.

#### THROUGH PHYSIOLOGY TO PATHOLOGY IN COMPLICATIONS OF GALL-BLADDER DISEASE.

G. E. Dickinson of Jersey City discusses complications of gall-bladder disease. A nervous condition resembling shock may follow severe pain, characterized by high tension, cold extremities, and pallid, moist skin, and may end in heart complications. The parotid may be affected, while acute dilatation of the stomach or intestines may result. Defective elimination of bile may cause constipation, and intestinal gases, with putrefaction of intestinal contents, and ascent of bacteria, while ulceration of the walls may come from injury of the intestinal epithelia and capillary endothelia. In cystic duct obstruction we have pancreatitis. Obstruction of bile, if intermittent, gives interstitial hyperplasia, hypertrophic cirrhosis, and contraction. When permanent we get degeneration and large, thick gall-bladders. Inflammation may extend to surrounding structures, producing traction by adhesions. Pressure of calculi may cause ulceration or necrosis of the walls of the gall-bladder and peritonitis. Impacted calculi may end in adenocarcinoma.—Medical Record, July 27, 1907.

## **Society Reports.**

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### **AMERICAN PROCTOLOGIC SOCIETY.**

When inflamed or infected, they may give rise reflexly to pruritus ani.

The ninth annual meeting was held at Atlantic City, N. J., June 3 and 4, 1907, the president, Dr. Samuel G. Gant, in the chair.

The following officers were elected: President, A. Bennett Cooke, M. D., Nashville, Tenn.; Vice-president, Louis J. Krouse, M. D., Cincinnati, Ohio; Secretary-Treasurer, Lewis H. Adler, Jr., M. D., Philadelphia, Pa.; and the Executive Council, J. Rawson Pennington, M. D., Chicago, Ill.; Chairman, Samuel G. Gant, M. D., N. Y. City, N. Y.; A. Bennett Cooke, M. D., Nashville, Tenn.; Lewis H. Adler, Jr., Philadelphia, Pa.

The place of meeting for 1908 is Chicago, Ill., the time to be announced later.

The following were elected members of the Society: Dr. Jerome M. Lynch of New York City; Dr. Jas. A. McVeigh and Dr. J. A. MacMillan of Detroit, Mich.

The following is an abstract of the principal papers read:

#### **PRESIDENT'S ADDRESS.**

The President, Dr. Samuel G. Gant, of New York City, said "that the annual meetings of the society were like a post-graduate school where advanced information in proctology could be obtained by the members. He considered it unwise to admit to membership in the society the general surgeon and young rectal specialists of less than five years experience in this special work, because the membership would become too large and the papers contributed by them would not meet the requirements.

He maintained that the proctologist of the future, in order to be successful, must have a thorough literary and medical education, a hospital training and clinical facilities, and that he must be clever, industrious and persistent. He emphasized the necessity of educating both the profession and the laity, as to the remarkably improved methods now employed in the handling of patients suffering from disease in the lower bowels. He also said it was the duty of the proctologist to

demonstrate by his work and writing that most tubercular fistulæ were curable and that the curing of ordinary fistulæ did not tend to bring about lung or skin affections as was formerly believed; that fecal incontinence does not follow fistula operations, when the muscle is cut at a right angle and the wound is properly dressed; that many rectal diseases, such as fissures, ulcers, small fistulae and some hemorrhoids can be operated upon under local anaesthesia; and that in the majority of instances, constipation and chronic diarrhea are curable by local and surgical measures.

Finally, he emphasized the fact that the etiology of many discomforts, nervous and reflex phenomena, usually attributed to the genital organs is frequently to be found in some pathologic process located in the sigmoid rectum or anus.

#### REPORT ON PROCTOLOGIC LITERATURE FROM JUNE, 1906, TO JUNE, 1907.

Dr. Samuel T. Earle, Baltimore, Md., read his report on Proctologic Literature, covering a period from June, 1906, to June, 1907, in which he said: "That there has been nothing startling in proctologic literature in the past twelve months, your committee is gratified with the steady progress in this branch of medicine and surgery, as has been reflected in the literature on this subject. Especially gratifying have been the recommendations for the radical treatment of carcinoma of the upper rectum and sigmoid, as set forth in the papers of Samuel G. Gant, W. J. and C. H. Mayo, and James P. Tuttle, in which they all recount the combined advantages of the abdominal and perineal routes, which we think will greatly lessen the likelihood of recurrences, and increase the number of permanent cures. We note with pleasure the systematic efforts that are being made in the study of the etiology of pruritus ani. The paper of Wallace of London in 1905 on the study of this question, stimulated the efforts of others in this direction, and we find an excellent paper by J. C. Hill of Boston, on the same, in the Boston Medical and Surgical Journal, 1906. In this article, he takes the stand with Wallace that there is always a cause for this malady in which the pruritus is only a local symptom. We quote him as follows: "Pruritus ani is the symptom caused by unnatural moisture or discharges, produced either by lesions about the anus or by conges-

tion, or some pathologic condition in the rectum or sigmoid. It is due to one of five causes. First, and by far the most important are superficial ulcerations, or abrasions of the anal canal. Second, catarrhal diseases. Third, external hemorrhoids. Fourth, inflammation or irritation of the crypts of Morgagni. The free borders or valves of these crypts consist chiefly of nerve fibres, ganglion cells and connective tissue. When inflamed or infected, they may give rise reflexly to pruritus ani. The writer calls attention to the tags which project from the margin of these valves as accessory sense organs. When hypertrophied or elongated they cause many distressing symptoms about the anus, viz., creeping, crawling sensations and itching. Fifth, small polypi of the anal canal."

It is not only necessary to remove the exciting cause of the disease, but, also to direct appropriate treatment to the unnatural conditions of the skin. In this connection your committee is glad to be able to report a number of cases of the aggravated form of this disease, which had failed to respond to the usual local and constitutional methods that were successfully treated by Dr. Ball's recommendation of dividing the anal nerves. These have been reported by Drs. Mattin and Earle.

Dr. Charles B. Kelsey calls attention to the office treatment of hemorrhoids by puncture with the electric cauter. The method is to make numerous puncture with a pointed cautery to the internal hemorrhoids. This method has been used for the past ten years in lieu of that by injection, with most satisfactory results, and without any unfavorable effect. For the details of the method, I would refer to his article in the *Therapeutic Gazette* for March 15, 1906. The reviewer would respectfully report with reference to this suggestion, that about ten years ago he tried in a number of cases, but with only temporary success where the hemorrhoids were large. It answered very well in small capillary hemorrhoids. J. A. Hartwell in the *Annals of Surgery*, Philadelphia, for 1906, Vol. 43, page 146, reports a case of resection of the rectum for syphilitic stricture, with end to end anastomosis. As might have been predicted, it recurred, and while it was necessary to continue dilating, he was not hopeful of results. Your committee would remind its members that such radical measures seldom accomplish the desired results, as recurrence is almost inevitable.

"Additional Experience With a New Procedure in Operating for Ano-Rectal-Fistula," by Dr. J. R. Pennington, Chicago, Ill., who said: "I have found the employment of the seton in operating on cases of anorectal fistula greatly aids in preserving the contour of the anus and the functions of the sphincter muscles.

The technique in using the seton is as follows: After all of the fistulous tracts external to the sphincter are divided a probe-pointed director is passed into the bowel through the remaining tract and an incision made on its distal side. This incision should extend far enough distally to divide all or a part of the fibers of the external sphincter and in such a direction as to locate the transferred internal opening at or near the anal margin. Then, turning the knife, make an incision—Salmon's "back cut"—on the proximal side of the tract. A seton is then passed through the opening entering the bowel and tied loosely around the tissues remaining and undivided.

The wound is dressed as after the ordinary incision operation for fistula. At the end of twenty-four to thirty-six hours the wound is re-dressed, care being taken to dress it so that the opening entering the bowel will be made to heal from the proximal toward the distal side. The object in doing this is to advance the final fistulous tract as far distally (toward the skin) as the case will permit, so that, if possible, it will pass through or distally to the fibers of the external sphincter, when the healing process is complete.

As a rule the enlarged tract entering the bowel soon closes, with the exception of the part through which the seton passes. As soon as this has occurred the seton may be removed, and by the time the external wound is healed the tract entering the bowel will possibly have closed also. Should it not, at any time later this little tract may be dissected out and the remaining fibers of the muscle sewed together, thus preserving the contour of the anus and the functions of sphincters.

"Occult Hemorrhoids from the Rectum," by Dr. William M. Beach, Pittsburg, Pa., who stated:

1. Occult blood in the stool indicates disease high up in the gastrointestinal tract.

2. Accompanied by certain rational symptoms as pain localized, the original of occult blood can be noted,

3. The discovery of blood in the stool may enable us to predict hemorrhage or prevent disaster.

4. The most frequent sources of occult blood are in the order named: stomach, duodenum and Caput Coli.

6. The Alôin-turpentine test as practiced by Dr. J. Dutton Steele, of Philadelphia, is recommended.

6. Proctologists should make an examination for occult blood a routine practice in cases of anemia accompanied by diarrhoea or constipation.

"Etiology and Symptoms of Fissure," by Dr. C. F. Martin, of Philadelphia, Pa., who said: "The fissure is usually situated posteriorly and directly over the 'white line' of Hilton, due to the arrangement of the fibers of the external sphincter and to the fact that the anal canal has less elasticity directly over that line. Most fissures start as the result of the distention of the canal by hard feces and excessive straining at stool. Those situated anteriorly, are often seen after confinement due to the pressure of the fetal head upon the perineum.

The sentinel pile is noted in most cases if the fissure has been present for any length of time. It is a simple inflammatory hypertrophy. Hypertrophy of the anal papilæ does not appear to be an important factor in the causation of fisture. True hypertrophy of the sphincters is rarely seen, but in its place we find an excessive irritability of the external sphincter.

The distinctive symptoms of this disease is pain or sphincteralgia, preceded by a "pain interval" of from one minute to an hour, during which time the patient has comparative comfort. The pain is caused by spasm of the sphincter compressing the nerves in the ulcer. This contraction interferes with the perianal circulation and renders the inflamed nerves more sensitive. The "pain interval" is caused by a temporary improvement in the perianal circulation produced by the straining efforts at stool.

The constipation of fissure often precedes the formation of the ulcer, an irritable sphincter being the underlying factor in the production of this condition. The constipation increases after the formation of the ulcer due to the fear of the patient of the pain following stool.

The treatment consists in the divulsion of the sphincters and the usual stimulating after treatment. The sentinel pile should be removed at the time of divulsion. Division of the external sphincter is not advised, for frequently it does not unite and eventually atrophies. Fistulæ, abscesses and fecal impaction are mentioned as frequent complications of fissure and call for appropriate treatment.

"Local Versus General Anesthesia in Rectal Surgery," by Dr. G. B. Evans, Dayton, Ohio, who stated that "pain naturally is the common curse and dread though relatively essential of the human family.

The law of self-preservation when an individual is threatened with pain is at once a law of resistance, manifest by intense expectancy and defiant attitude.

The shock incident to the terror of pain is incomparable to that which is likely to follow an abbreviated use of a general anesthetic. In consideration of the evolutionary plane occupied by the average American of today and the more remote period of his removal from the gorilla peripheral sensibility of the jungle, we are forced to conclude that he is more sensitive, and in need of greater consideration for the relief of pain. Because an operation can be done painlessly, it does not follow that there will not be subsequent suffering and some and perhaps severe shock.

But in this nerve block period of Creile and Pennington, and the Gant period of dermal and sub-dermal distention we are told there is scarcely any use any more for a general anesthetic. Do we not believe as proctologists that in our operative field, sensibility is most difficult to abolish, and would it not naturally appear that more narcosis is necessary in this kind of surgical work and as a consequence more shock? Again, would it not be possible by the combined use of general and local anesthesia less shock would ensue and more operations would be made with success. I believe that by using the local anesthetic preceding the general anesthesia we lessen the amount of the general anesthetic appreciably, diminish the dread and fear, and consequently diminish shock and danger thereby. Therefore, the combined method of narcosis, less anesthetic, suspending shock incident to conscious dread, as well as anesthetic shock, rendering more complete operative area—consequently more satisfactory work. It is simple to operate upon prolaps-

ing piles, but not so simple to operate upon piles above the sphincters yet demanding operative interference.

The injections of sterile solutions disturbs the parts anatomically. The frequent punctures through the tissues invite infection and infection trouble. You can never measure the nerve and seldom the surgical all of your patient. Its chief advantage is that occasionally you are able to do work in your office and even then unsatisfactorily.

I fail to see the advantage of operation under local anesthesia in your office and follow your patient home and give hypodermic of morphia over the usual custom of operating at home in the first place.

An operation for hemorrhoids is a matter of some seriousness—often attended by some shock—often bloody and the greatest caution should be observed that asepsis be obtained.

I do not think it best for our patients that general practitioners should be taught that aseptic precautions at the time of operation and rest at home for a few days, is unnecessary. Do we not magnify the applicability of local anesthesia, will not accidents occur, are we not sacrificing perfect scientific work, are we not belittling our chosen work—a class of operations that are important and not free from danger?

"The Sigmoidal Factor in Constipation," by Dr. E. A. Hamilton Columbus, Ohio, said: "In a certain per cent of intractable cases of constipation, organic change in the wall of the sigmoid is the controlling factor. This change is entirely independent of any disturbance which may occur on the outer surface of the viscus: e. g. malposition and pathologic flexures due to adhesions. The change in the gut occurs in the sub-mucous and muscular coats and consists of a round cell infiltration of these coats which subsequently contracts, thereby to a greater or less degree narrowing the lumen of the bowel. The round cells change into spindle cells subsequently undergoing a metamorphosis into true connective tissue. The contraction of this connective tissue so narrows the caliber of the sigmoid that constipation of an obstinate type must result. This change is not always limited to the sigmoid, it frequently involves the descending colon as well: in addition to the contraction of the gut it loses also its resilience which further adds to the difficulty of the passage of faecal debris. The

etiologic factor is the absorption of bacteria and toxic products from the sigmoidal contents. The mesentery is also involved and is thickened and shortened. The whole process is chronic, several years being required to bring out the condition. Surgery offers the only relief and anastomosis must be effected by any suitable surgical procedure between the unaffected position of the intestinal tract above and below the lesion.

A report of Two Cases of Sigmoidopexy, by Dr. S. T. Earle, Baltimore, Md., who said: "That in one of the cases there was the 3rd degree of prolapse of the rectum, the invagination of the upper part into the lower portion of the rectum; in the other case there was a very acute flexure of the sigmoid upon the rectum, both of the conditions, as is well known, are frequently due to an abnormally long meso-sigmoid. The symptoms in each case were obstinate and persistent constipation, frequent bearing down pains in the lower pelvis, a sense of weight and especially a feeling of unrelief for some hours following a stool, or an attempt at the same; associated with these local symptoms were darting pains in various parts of the body, nausea, anorexia; frequent headaches and the various neurotic symptoms that go to make up a typical case of neurasthenia. The case of invagination was diagnosed positively by a digital examination while straining at stool, the sulcus being distinctly felt with the finger; the case of acute flexure was diagnosed by means of the protoscope, the flexure being so acute that it was only possible to enter the sigmoid with the protoscope by getting the end of the latter around the flexure, and pulling it aside. The flexure was so acute that it obliterated the lumen of the bowel at this point. The technique of the operation is such as is given in Tuttle's & Gant's works on "Diseases of the Rectum and Anus." I met with no special difficulty in performing the operations. The meso-sigmoid was very long in both. I was particular in pulling off the abdominal peritoneum where the sigmoid was to be held in apposition and also in attaching the sigmoid to the transversalis fascia. Both cases made good recoveries, except that one was retarded by a stitch abscess. The results in both cases were most satisfactory and pronounced, with almost immediate relief of the persistent and obstinate constipation with the gradual disappearance of the neurotic symp-

toms. Dr. Gant has recently reported a number of sigmoidopexies and colopexies with most satisfactory results.

Dr. Clark in a paper read before the Medical and Gynecological Sections of the Medical and Chirurgical Faculty of Maryland, on Feb. 15, 1907, called attention to the frequent associations of gastropnoxis; floating kidney and enteropnoxis in the same individual."

#### "FECAL IMPACTION."

Dr. Lewis H. Adler, Jr., of Philadelphia, Pa., in a paper entitled "Fecal Impaction," called attention to the result of obstipation, or an attack of constipation causing an accumulation of feces in the caecum or in any part of the colon; but the term impaction, the subject of the paper, should be usually employed when such an accumulation occurs in the pouch or ampulla of the rectum, or in the sigmoid flexure.

Attention was called to the difference between an ordinary persistent constipation and an impaction, as the latter may follow from a single attack of constipation; whereas obstinate constipation may never, or only after a long period cause impaction. The symptoms of the two conditions are also very different, as an impaction is usually marked by a diarrhoea, whereas chronic constipation is associated with costiveness. After calling attention to the various causes of the malady under consideration and the symptoms of the same, the treatment was detailed as consisting primarily, in the removal of the mass, and, secondly in the relief of the inflammation of the mucous membrane occasioned by the irritating presence of the fecal matter as well as the removal of all causes which contribute to the constipated habit, which is undoubtedly the prime factor in most cases in producing an impaction.

The easier manner of breaking up the fecal mass is to put the patient under an anaesthetic and then to forcibly divulse the sphincters, after which the mass may be disintegrated by means of the finger, a lithotomy scoop or an old fashioned iron spoon. In women considerable assistance may be rendered by passing a couple of fingers into the vagina and by this means steadying the mass so that it may be the more readily broken.

In some instances the writer was able to break up an impaction without resorting to anaesthesia, simply by using the finger and sometimes by the additional use of a bivalve speculum and a rectal scoop or spoon.

Previous to resorting to instrumental aid in the removal of the impaction, the fecal mass may be softened and its passage facilitated by the use of enemas, especially is this so in cases in which the sigmoid is the part affected, in which situation material assistance cannot be gained by the employment of instruments. For the purpose of administering the injection a douche-bag holding several quarts is to be preferred. The injection substance should be composed of soap and water to which I have found the addition of glycerine of considerable benefit, a dessert-spoonful to a quart. When the impaction is in the sigmoid, the injection should be given through a Wales bougie, preferably the one modified by Dr. Dwight H. Murray, of Syracuse, New York, which is stiffer than the ordinary article sold; which latter is frequently useless for the purpose intended as it readily doubles on itself, and a high injection is rendered impossible by its use. When this method is employed the patient should be placed in the knee-chest posture.

A word of caution should be given here as to the danger surrounding the unguarded use of drastic purgative drugs in cases of impaction. By their employment peristalsis is increased and the fecal mass softened but the bowel in its inflamed and distended condition may be thereby the more easily ruptured, and, if in addition, a stricture is present, the caliber of the gut may be entirely occluded by forcing into it the hard fecal mass with the attendant symptoms and consequent of total obstruction of the intestines. So much for the treatment of the actual impaction.

"Pruritus Ani—Is it a disease per se or Merely a Symptom?"—By Dr. Louis J. Krouse, Cincinnati, Ohio, who quoted from the works of Bodenhamer, Agnew, Wright, Ball, Crepps, Gant, Matthews, Tuttle and others, their opinions regarding the etiology of this disease, and then stated "Pruritus Ani essentials is a disease which is due, not to a local, but to a constitutional cause, and is due to some trophic changes in the nerves supplying the parts." He further stated, that the changes occurring in the skin of the anus and surrounding parts, namely, the hypertrophy, the loss of pliability, and the absence of pigment, can only be explained on the faulty nervous supply of the parts. He showed that an increase of pigment ought to accompany severe itching, and not a total disappearance, and finishes his article by saying that "The

absorption of the normal coloring matter of the affected area does occur, notwithstanding that the epidermis was not destroyed, and said "A similar process of absorption takes place in leucoderma.

All authorities acknowledge that the cause of the latter disease is to be found in the nervous system, and concluded with the statement "That Pruritus Ani, at least in such cases, is a disease per se and not a symptom."

(a) Dr. Dwight H. Murray of Syracuse, New York, presented a new Hemorrhoidal Clamp which had the following qualities in combination, that make a first class instrument. Viz: Scissors shaped, parallel jaws: can be closed and released instantly without the use of a thumb screw, thereby saving much time while operating.

The Goodell dilator reversed is used as the ground principle for the lock.

(b) Dr. Dwight H. Murray of Syracuse, New York, reported the case of a man 48 years old who had been troubled with sciatica in the right leg for two years and had also been a sufferer from hemorrhoids for ten years, having frequent profuse hemorrhages therefrom.

The hemorrhoids had not been treated. The sciatic nerve had been stretched and treated by various methods, by a physician at his home town, included in which was the following completed in three sittings two (2) days apart.

At the first sitting, six hypodermic injections 1-150 gr. of atrophine each were given into the sheath of the sciatic nerve. At the second sitting, seven injections of the same amount, and at the third sitting, eight injections were given as before and one extra into the nerve before it leaves the pelvis. The patient was unconscious for fourteen hours after the last sitting, very little improvement resulted.

In November 1906, the author was first consulted, and on December 12, 1906, operated on him for internal hemorrhoids. He made the usual recovery up to the ninth day, when there was a sudden profuse secondary hemorrhage. The patient was almost ex-sanguinated before the author arrived.

He immediately examined, found the superior hemorrhoidal artery was throwing a full sized stream, this was secured, the patient stimu-

lated and made an uneventful but slow recovery. The patient has had no sciatic pain since the operation.

Dr. Murray concluded that inasmuch as sciatica is often symptomatic, that no such severe treatment is justified until all possible reflex causes are first removed.

The cause of the hemorrhage was probably due to the thrombus or eschar at the end of the vessel being thrown off before thorough healing had taken place, and was influenced largely by his general anemic condition before operation.

"The Treatment of Ischio-Rectal and Pelvi-Rectal Abscesses," by Dr. T. Chittenden Hill, of Boston, Mass., who said "That he employed general anaesthesia produced with ethyl chloride for the ischio-rectal abscess and ether anaesthesia for the pelvi-rectal abscess.

His experience with infiltration anaesthesia has been unsatisfactory. He emphasized the importance of an early incision for perirectal abscesses, claiming that when acute symptoms have existed for a day or two, with pain and tenderness, even before there is much edema or discoloration of the skin, long before fluctuation can be detected, an incision may prevent abscess formation by allowing the escape of blood or serous exudate from the engorged blood vessels.

He advised a T incision and breaking up the existing septa with the finger, after which the sphincters are divulsed. He believed squeezing, scraping or disinfecting an acute abscess to be a great mistake, as it only serves to destroy the new granulation tissue and so spread the infecting bacteria. For the deeper ischio-rectal and in all pelvi-rectal abscesses he recommended rubber drainage tubes, discarding their use as quickly as possible in the after-treatment.

He believed that the great majority of pelvi-rectal abscesses should be reached by perineal dissection."

"Cryptitis," by Dr. J. Coles Brick, Philadelphia, Pa., who said: "The anal valves and crypts, first pointed out by Morgagni, and called after his name, are found as vestigial remains of the junction of the rectal mucous membrane with the skin. They vary in number and size, but are absent in the anterior and posterior commissures. They have no known functions, but are the cause of obscure symptoms, when dis-

eased, and from the fact that the valve or covering part of the crypt may conceal the diseased area, repeated examination will fail to show the lesion, unless each crypt is probed, when tenderness or pain will be felt. A conical fenetrated speculum is the best to use, and when the diagnosis has been made, the valve should be removed and the crypt converted into a raw surface, so that healing will obliterate it."

Dr. A. B. Cooke read a paper on "Observations on Certain Points in the Anatomy and Physiology of the Rectum." He expressed the view that the usual conception of the external sphincter muscle is erroneous, that under normal conditions it is not in a state of tonic contraction, but, on the other hand, is at rest and passive, the shape of the muscle and the arrangement of its fibres being such that the anal aperature is maintained in a state of passive closure. It is not conceivable that a VOLUNTARY muscle should require the constant action of nerve force to keep it in a state of rest. The only action of this muscle is to voluntarily oppose or terminate the act of defecation by tonic contraction.

With reference to the internal sphincter, the essayist observed that there is no occasion to credit this muscle with any special action in addition to that of the circular coat of the bowel, of which it is a part. By reason of its location and thickness, it probably exercises some passive sphincter control, but its chief action is undoubtedly that of a detrusor, serving to complete the expulsion of feces and keep the anal canal free of contents.

The levator ani muscles, acting together, constitute the sphincter of the proximal extremity of the anal canal. To understand this it is only necessary to remember (1) that the upper or pelvic surface of these muscles presents a deep, funnel-shaped concavity, the beginning of the anal canal being at the lowest point; (2) the strong bundles of fibers which unite immediately behind the rectum arise in front from the pubis and anterior portion of the fascial line and pass downward and backward in close relation with the lateral walls of the rectum, crossing it obliquely at the upper limit of the anal canal.

The well known difficulty of voiding urine while a costive stool is being expelled, which is usually attributed to the action of the levatores ani, is due rather to the pressure of the fecal mass upon the prostatic

and membranous portions of the urethra, since, at the time of defecation, these muscles, like the sphincters, must be in a state of relaxation.

The part played by the anal canal in defecation is purely passive, except at the completion of the act when the voluntary muscles which enclose it are strongly contracted, expelling any remnant of feces and bringing its walls again into their normal relation when at rest of close apposition.

The essayist dissented from the commonly accepted teaching that there is an inhibitory center in the cord which presides over the action of the external sphincter and which is called into action at the time of defecation to inhibit its tonic.

The relaxation which occurs at such times seemed to him fully explained by the mechanical pressure of the descending mass upon a structure which only offers passive resistance unless contracted by voluntary effort, and which possesses sufficient resilience, independent of any nerve influence to regain its normal form and tone as soon as the pressure is removed."

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#### REINFECTION WITH SYPHILIS.

James Brew of Nashville describes a case seen by himself and treated at various times by two reputable physicians, in which there was every reason to believe that syphilis had existed and been cured and a reinfection had occurred. Most syphilographers at the present day agree in saying that such a cure and reinfection are possible, although rare. The patient described was treated carefully for an undoubted attack of syphilis, from which he recovered and remained without any syphilitic manifestations for fifteen years. He was then treated for a hard chancre followed by a macular eruption and sore throat. Marrying then, a syphilitic child was born to the couple, although the mother showed no evidences of ever having had the disease. The manifestations of the second attack could not have been tertiary in their nature. —Medical Record, July 27, 1907.



# Editorial.

**W. H. BELL, M. D., Editor.**

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## DR. BROWN'S SECOND COMMUNICATION.

We are pleased to see that rest and sea-air, together with the diversions incident to such an attractive resort as Atlantic City, have worked a happy transformation in the attitude of our friend, Dr. Geo. S. Brown, toward medical organization in this State, the transformation being indicated by a second communication from him, which appears in this issue of the Journal. The Doctor is too good a diagnostician not to recognize this change himself, and too true to scientific methods not to acknowledge it, which he very generously does in the communication referred to.

The Journal warmly reciprocates this spirit, and unhesitatingly announces that it always prefers peace to war, never engaging in the latter except when assailed, or when the State Medical Association is assailed, either as to its principles or policies.

The Doctor seems still to cling, however, to the idea that injustice was done him by the way in which his now historic resolutions were dealt with. Evidently he overlooks the fact that in all parliamentary and legislative bodies a committee on resolutions is provided, to which all resolutions introduced are, without discussion, referred. When resolutions so referred have been considered in committee and are brought back to the main body, with recommendations, they are before that body for such disposition as it may see fit to make of them. When the Board of Censors brought Dr. Brown's resolutions back to the Association it did so with the recommendation that they be not discussed, for the reason that if discussed and adopted the Association would thereby commit itself to a violation of its own charter, consequently such action would have been null and void; if discussed and not adopted time would have been thrown away. In either event, therefore, a discussion of the resolutions would have been "love's labor lost." The Doctor is in error in supposing that the resolutions were killed in Committee, or that they were killed as a "legislative trick to scotch effusive cranks." The Association itself in open session was the executioner, and by the very decided vote of 90 to 14. In the light of what has been said our readers are at liberty to judge of the good taste or logic displayed by the Doctor when he suggests a "legislative trick" on the part of either the Association or the Board of Censors. Such a reflection is unworthy of him, and even if he claims a monopoly on honesty, he certainly cannot lay claim to a monopoly on the knowledge and application of parliamentary law. Had he permitted a little of the generous feeling that pervades other parts of his communication to banish such a suspicion from his mind it is certain that his conscience would not have been disturbed thereby.

The Doctor disclaims any recollection of having been granted, a year later, an opportunity of discussing his resolutions, and in alluding to the circumstance speaks of the "arrogance and absurdity of such an offer." These are ugly words indeed to be applied to an offer that

was made with the best intentions. The gentleman who presided over the meeting of the Association at which the offer was made informs the Journal that, although well aware that Dr. Brown could not claim a hearing as a right, he determined in the abundance of generosity to accord it to him, believing it better to violate a parliamentary rule than to have a member complaining that free discussion could not be obtained on the floor of the Association.

With the offer made in the spirit the president tells us it was done we submit to the Doctor himself whether he thinks it generous or just to speak of the offer as "illegal, arbitrary, irrelevant, and illegitimate." If it was all this why was it not declined at the time? On the contrary, it was accepted, and according to the Doctor's own confession very poor use of it was made. Inasmuch as notice was given him the night before that the offer would be made he need not have been "speechless." The year before when discussion of the resolutions was refused by the Association the action was regarded by our correspondent as unjust, oppressive, and in violation of the rights of free speech; a year later when the president offers, and the Association permits, discussion our same correspondent pronounces the action "illegal, arbitrary, irrelevant, and illegitimate." Was there ever a better example of the saying, "be damned if you don't and be damned if you do?"

Neither does the Doctor's sentimental allusion do away with the inconsistency of his position. A lover who would be so careless or uninformed as to misdirect his letters should not expect anything better than delay, or worse, that his missives would ultimately find their way into the dead letter office. Likewise, when a reformer undertakes to revolutionize a system conceived, and after long study formulated, by a great philosopher he should go about it in such way as at least to be entitled to a hearing.

We cheerfully accept the Doctor's assurance that he is not nursing a grievance, but when he couples with this protest a somewhat ostentatious announcement of the doctrine of "free discussion, universal suffrage, and majority rule" we insist that each of the components of such a proposition—high sounding as they are—admits of very considerable qualification.

Free discussion when in order may be a good thing, when out of order may be a bad thing; universal suffrage as an abstract idea is a fine sentiment, but it is doubtful whether the Doctor himself would insist upon it for Alabama and the South; majority rule in the broad and unqualified sense may lead to great oppression and wrong, as was so forcefully pointed out many years ago by that master statesman, Calhoun. Thus, the sentiment the Doctor announces may do very well for a fourth of July flourish, when people are not expected to go into any analyses, but will not always do for a working basis.

Our correspondent closes his communication by an assurance that neither he nor anyone else is trying to tear down our system of organization, and asks whether the "trouble makers tried to do anything at the Mobile meeting?" While the "trouble makers," as he calls them, did not disturb at that meeting, and never have succeeded in disturbing the equanimity of the great body of loyal members of the Association, yet our correspondent can scarcely be ignorant of the fact that at the Mobile meeting another set of resolutions was sent in which met with overwhelming defeat. However honest the advocates of the resolutions may have been the Association evidently regarded them as revolutionary and unwise, and therefore defeated them. Inasmuch as the Association is the arbiter we must accept its decisions as final and just.

Our correspondent is entirely welcome to regard the scientific part of the work of the Association, to which he has been a regular and liberal contributor, as of paramount importance, but he should permit others, while not at all underestimating the value of that scientific work, to believe that its application to the practical administration of a public health system is the highest and most altruistic aim toward which we can strive.

The Doctor's advice: "You really should not make light of those papers and discussions" is wholly gratuitous and unnecessary, for we would not be guilty of doing such an absurd thing. But it seems highly necessary that we should paraphrase the advice a little and return it to him in these words: "You should not speak contemptuously of our public health machinery." According to the Doctor's position it would have been entirely proper for our forefathers to meet annually and

read papers on, and discuss theories of, government, but entirely wrong to put any ideas that might have been evolved into practical operation by organizing and administering civil governments. Evidently he is an advocate and follower of the Platonic, not the Baconian system of philosophy. Let us not entertain a contempt for utilitarianism, but rather let us apply our science as broadly as we can, not to individual cases of diseases merely, but to the protection of the great body of the people from infection, which cannot be done in any other way than by the organization and enforcement of a great public health system. If the doctors do not organize and administer such a system, who can?

While this discussion, pro and con, has had its disagreeable side, yet it is to be hoped that it has had another and better side, and that it may result in advancing and solidifying the cause of organized medicine in Alabama.

In bringing this discussion to a close the Editor expresses the most fraternal feelings for his antagonist, and hopes to have the pleasure of seeing him at home among his friends soon, fully restored to health, and willing to work in the great cause in which we are engaged, even though he does not endorse every principle and detail in our system of organization.

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#### LAWS OF INTEREST TO DOCTORS ENACTED BY THE LEGISLATURE OF ALABAMA.

It has been claimed that the Legislature of this state which recently adjourned has accomplished more for the state of Alabama and its people than any body of law-makers which has convened for the past twenty years. On the other hand, it has been said that "there will be enough litigation grow out of the acts of the law-makers to keep the lawyers busy for ten years to come."

However this may be, it certainly was a busy legislature, and was very kind to the doctors and people of the state in giving hearty support to all measures to promote public health. This was shown by passing most of the bills in which the doctors were especially interested.

The following bills were enacted into laws:—

(1) A bill providing for the establishment and maintenance of a State Sanitarium for the treatment of curable cases of Tuberculosis and for disseminating information upon the nature, treatment and cure of tubercular diseases. An appropriation of \$40,000 was made

for its establishment, and an annual appropriation of \$10,000 for its maintenance.

(2) A bill providing for an epileptic colony at which epileptics are to be cared for.

(3) A bill regulating the practice of medicine. This is the bill providing for doing away with the county boards of examiners and establishing one state board. A copy of it was published in the April number of the Journal. It goes into effect on September 1, 1907, when no more examinations will be made by county boards.

(4) A bill providing for better salaries for county health officers.

(5) A bill increasing the annual appropriation to the state board of health from \$4,000 to \$15,000.

(6) A bill amending the general public health laws of the state.

(7) A bill increasing the appropriation for quarantine purposes from \$10,000 to \$20,000.

The following bills failed to pass:—

(1) A bill regulating the practice of midwifery in the state.

(2) A bill legalizing the dissection of human bodies.

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#### THE SOUTHERN MEDICAL ASSOCIATION.

The first meeting of the Southern Medical Association will be held in Birmingham, Ala., on Sept. 24th, 25th and 26th. This meeting was to have been held in October, but has been changed to the above date.

An interesting program is being arranged and will be mailed out soon.

A cordial welcome will be given the Association by the profession of this city, and it is hoped that there will be a good attendance and a most successful meeting.

This Association was given official recognition by the American Medical Association at its last meeting as the Southern and Gulf Branch of the American Medical Association. Dr. H. H. Martin, of Savannah, Ga., is the president, and Dr. Raymond Wallace, of Chattanooga, Tenn., is secretary.

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#### INSURANCE FEES.

The Mutual Life Insurance Co., of New York, and the Equitable Life Assurance Society, have both recently announced that they will pay a fee of \$5.00, beginning August 1st, for each examination for life insurance.

## Personal Notes.

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Dr. D. F. Talley, of this city, has returned from a trip through the northwest.

Dr. H. A. Elkourie, of Birmingham, spent last month in New York and other eastern cities.

Dr. Carl Fox, of Birmingham, is spending the month of August in Canada and Nova Scotia.

Dr. J. D. S. Davis, of Birmingham, is spending a few months in the medical centers of Europe.

Dr. Cabot Lull, of Birmingham, has returned from several weeks' stay in Boston and Baltimore.

Dr. Mack Rogers and wife, of this city, have returned after a two weeks' stay on the gulf coast.

Dr. W. T. Berry, of Birmingham, is spending a few weeks in New York doing post-graduate work. We publish a letter from him in this issue.

Dr. W. L. Heflin, of Roanoke, Ala., the venerable father of our Drs. Wyatt and Howell Heflin of this city, spent a few days here on his way to Blount Springs recently.

Among the out of town doctors who have recently visited Birmingham are: Dr. R. C. Jones, Abernant, Ala.; Dr. J. L. Batson, Gurnee, Ala.; Dr. J. S. Moore, Centerville, Ala.; Dr. T. J. Bickley, Calera, Ala.; Dr. W. C. Head, Johns, Ala.; Dr. J. I. Reid, Aldrich, Ala.; Dr. J. F. Alexander, Blocton, Ala.; Dr. R. C. Curtis, Garnsey, Ala.; Dr. D. L. Wilkinson, Montevallo, Ala., and Dr. J. E. Pearson, Sylacauga, Ala.

The senate adopted a resolution thanking Dr. Sprating, superintendent of the New York Epileptic sanatorium for an offer of 400 acres of land in Chambers county as a site for the epileptic colony to be established by Alabama under the McWhorter bill. The letter was read by Dr. McWhorter, to whom it was addressed. No action was taken with a view of accepting the land. Dr. Spratling is a native of Chambers county.

### Obituaries.

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#### DR. J. B. KILLABREW.

We were pained to learn of the sudden death on July 24th of Dr. J. B. Killabrew, of Mobile, Ala. On returning from a ball game with friends in an automobile as they approached a crossing of the railroad they discovered that a train was backing across the road. The driver turned the automobile over the bluff, but Dr. Killabrew jumped out and fell under the wheels of the train, and was killed instantly.

Dr. Killabrew was a popular member of the profession in Mobile, was President of the Mobile County Medical Society at the time of his death, and his early death is greatly deplored by his hundreds of friends in the profession all over the state. He was visiting gynecologist to the Mobile City Hospital and adjunct professor of gynecology in the Medical Department of the University of Alabama.

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#### TRIBUTE TO J. H. GUNN, M. D.

John Hamlin Gunn, M. D., was born at Benton, Dallas county, Alabama, July 23, 1840, and died at St. Vincent's Hospital, in Birmingham, of gun-shot wound received in Calera, at the hands of a policeman, in the following manner:

As Dr. Gunn was walking along the street in Calera, which was his happy home for so many years, he overtook a policeman who had charge of a very obstinate and rebellious prisoner who was struggling violently to resist his being taken to the calaboose. In this struggle the prisoner was struck severely by the policeman. Dr. Gunn, ever having a heart full of tender sympathy, for suffering humanity, uttered an appeal to the policeman by saying, "Don't strike that man any more." The policeman asked who struck him? Dr. Gunn's reply was "you did," whereupon the policeman fired two shots at Dr. Gunn, both balls of which entered the body.

He was at once taken to St. Vincent's Hospital, accompanied by Dr. C. C. Oliver, of Calera, and the spleen, which was severely torn, was extirpated in its entirety. The attending surgeon, in giving an immediate cause of death in this case, stated that the patient died of hemorrhage of the spleen and its vessels.

Dr. Gunn had every attention that could be given him, and all that surgical skill could do to relieve the pangs of his death wounds, which he bore with calmness and resignation. No permanent relief could be obtained. The death-blow had been given, and in this manner was taken from this life a skillful physician, an affectionate father, a loving husband, and a citizen noted for honor and integrity.

He lingered for a while, but finally succumbed to his wounds, and breathed his last July 3, 1907.

Dr. Gunn was buried at Calera, Ala., which place has been his residence for many years, on the 4th day of July, 1907. Almost universal sympathy was manifested; and the very large attendance at his burying bore testimony to his popularity as a physician. He leaves a widow, Mrs. Julia Gunn, and three children, viz: two sons, Messrs, Tipton and Ellwood, and a little daughter, Julia, with a host of friends to mourn his loss.

Dr. Gunn was a member of the Shelby County Medical Society almost ever since its organization, and was held in high esteem by the medical fraternity generally, and especially so by the members of this society. He occupied several positions of honor and trust in the society, and during his long membership held the confidence and respect of the brethren. He was untiring in his efforts to maintain a high standard of excellence in our society, and was ever punctual in attendance upon its councils, except when he was unavoidably hindered; it is, therefore, not only proper as an act of justice to the character of our deceased brother, but it becomes a pleasurable duty (as brother members of the society, to which he was ever loyal) to give this feeble expression to the sentiments we entertained for him while living, and which now, that he is dead, emphasize themselves so potently as we retrospect the career of our deceased brother.

At the first meeting of the society after the death of Dr. Gunn a committee was appointed to draft suitable resolutions in which to express our respect and fraternal love for the deceased brother, our sympathy with the bereaved family, and to give to the public the high standing of Dr. Gunn in his own home county. The committee thus empowered submitted the following preamble and resolutions, which were unanimously adopted with a rising vote and bowed heads:

Whereas, the death angel has entered our fold and removed from our ranks one of our most honored and trusted members, and in such a manner as to impress us most profoundly with that scriptural truth that "in the midst of life we are in death;" now, therefore, we who were associated with our deceased brother, Dr. Gunn, find it a pleasure to testify to his character as a faithful friend, an indefatigable co-worker, a kind and efficient physician, and a worthy and honored citizen; and we deeply deplore his loss as a member of our society. Therefore be it

Resolved, That we tender to his bereaved family our deepest sympathy and mourn with them their great loss in his death.

Be it further resolved, That a copy of these resolutions be transmitted to the Shelby Sentinel and one to the Alabama Medical Journal for publication, and that a copy be spread upon the minutes of the Shelby County Medical Society.

Respectfully submitted,

J. R. Morgan, M. D., Chairman,

C. C. Oliver, M. D.,

D. L. Wilkinson, M. D.,

J. W. Acker, M. D.,

Committee.

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### Book Notices.

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The Effect of Diet on Endurance. By Irvin Fisher, Ph. D., New Haven, Conn.

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A Graphic Method in Practical Dietetics. Irving Fisher, Ph. D., New Haven, Conn.

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Uncle Remus Magazine, August Number. Joel Chandler Harris, Ed., Atlanta, Ga.

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Diseases of the Rectum and Intestines. By W. C. Brinkerhoff, M. D., Chicago. Price \$2.00.

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Fifty-Eighth Annual Report of the Central Indiana Hospital for Insane for year ending Oct., 1906.

The Seventeenth Annual Report of the Eye, Ear, Nose and Throat Hospital, New Orleans, La., 1906.

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Descriptions and Classification of Varieties of American Upland Cotton. By J. F. Duggar, Director, Auburn, Ala.

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The Physiological Effect of the Waters of the Hot Springs of Arkansas. E. H. Dartin, M. D., Hot Springs, Ark. Reprint from Miss. Med. Monthly.

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Practical Legislation for the Prevention of Blindness from Ophthalmia Neonatorum. By F. Park Lewis, M. D., Buffalo, N. Y. Reprint from N. Y. State Jor. of Med.

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Bulletin No. 35. Hygienic Laboratory. Report on the Origin and Prevalence of Typhoid Fever in the District of Columbia. By M. J. Rosenan, L. L. Lumsden, and Joseph K. Kastle. Government Printing office, Washington, 1907.

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Bulletin No. 34. Hygienic Laboratory. I. A gramofilaria georgina n. sp. an apparently new Roundworm parasite. II. The Zoological characters of the Roundworm Genus. Filaria Muella, 1787. III. Three New American Cases of Infection of Man with Horse-hair Worms with Summary of all cases reported to date. By Ch. Wardell Stiles. Government Printing Office. May, 1907.

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*A Manual of Surgery.* For Students and Physicians. By Francis T. Stewart, M. D., Prof. Surgery, Philadelphia Polyclinic; Associate in Surg., Jefferson Med. Col.; Surgeon to the Germantown Hospital; Out-Patient Surgeon to the Pennsylvania Hospital. P. Blakiston's Son & Co., Philadelphia, Publishers. Price \$3.50 net.

This is one of the leather bound series of Medical Manuals of the publishers.

The author announces that this volume has been prepared for the undergraduate, whose crowded times demand a manual stripped of verbiage and unessentials, and for the medical practitioner who seeks a guide

to present day surgery. In a brief and practical way he has given the essential facts which the student must know, and such suggestions in diagnosis and treatment that will be of aid to the physician in his daily practice. It has 504 illustrations, many of them being original. We commend it as an up to date, concise and useful manual.

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*Manual of the Diseases of the Eye.* By Charles H. May, M. D. Fifth Edition, Revised. Wm. Wood & Company, New York, Publishers. Price \$2.00 net.

The favor with which this book has been received is manifest by the rapidity of the exhaustion of the fourth edition, which appeared in August, 1905, and was reprinted in October, 1905. In this, the fifth, it has been brought up to date, although the size has not been increased, the author adhering to his original plan of presenting a book for the student and general practitioner. To these we commend it. The common diseases of the eye, which the general practitioner is called upon to treat, are described with a fair degree of fullness, while the rare conditions are merely mentioned.

The book has 362 original illustrations, including 22 plates, with 62 colored figures.

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*International Clinics.* A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, etc., etc. By Leading Members of the Medical Profession throughout the World. Edited by W. T. Longcope, M. D., Philadelphia. Published by J. B. Lippincott Company. \$3.00. Volume II. Seventeenth Series, 1907.

This is one of the best of this most excellent series, as it is the latest. It has an interesting article on Vaccine Treatment of Infectious Diseases by Dr. Cole. One on The Treatment of Rheumatism by Dr. Abrahams, another on a Plea for Laparotomy Rather than Paracentesis in Ascites by Dr. Dock. Among the articles on Surgery the one by Dr. Bodine on local anesthesia, and claiming that general anesthesia is unjustifiable in the radical cure of hernia is of interest. Post-partum Hemorrhage and Its Treatment by Dr. DeLee is a splendid article. In fact, this volume is full of good articles and furnishes a fine collection of timely and valuable essays and lectures.

## Miscellaneous Notes.

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The neutrality and general purity of the salts entering the composition of Peacock's Bromides have been attested to by eminent chemists. This assurance in its purity and uniformity is of great moment to the general practitioner when he desires to employ a continuous bromide treatment. It is a palatable preparation and as each fluid drachm contains fifteen grains of the combined bromides, the dose is easily adjusted.

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### "TOBACCO HEART.

"This trouble comes under the head of cardiac neuroses. The innervation of the heart is disturbed, its action is weakened, irregular and intermittent; palpitation, precordial pains, faintness and vertigo are the consequences. The use of tobacco should be inhibited and a cactina pillet given every two or three hours, as the occasion demands. The patient will not only be benefited, but permanently cured if the treatment is continued for some time."—Charlotte Med. Journal.

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### THE THREE STAGES OF WOMAN. THIRD STAGE.

With the climacteric, the sexual life of woman is brought to a close, and is considered by some authorities as the most critical era of her existence.

Various disturbances of the circulatory, nervous and digestive systems as well as of the pelvic organs are usually characteristic of this period and are manifested many times by hot flashes, headache, melancholia, vertigo, neuralgia, etc.

For its calmative and sedative action upon the nervous system as well as for its normalizing effect upon the vasomotor system, Hayden's Viburnum Compound seems to have proven, as a result of twenty-six years of clinical investigation, to be a most satisfactory remedy from a therapeutic standpoint for administration just preceding, at the time of, and following the menopause.

## STUDIES OF JUVENILE CRIMINALS.

Arthur McDonald, of Washington, describes three sorts of studies entered into by him of juvenile criminals. The first is physical defects of sixty-five young criminals. Some of these defects are normal in lower races and in animals. The most frequent taints are hereditary nervous diseases, 95 per cent.; lung diseases, 64 per cent.; alcoholism, 62 per cent.; insanity, 47 per cent.; epilepsy, 32 per cent.; mental backwardness, 20 per cent. Next comes a study of 200 children from 6 to 12 years of age in a reformatory. A few of the parents were criminals. Many of the children were abandoned. Last is given the history of a criminal-born child. This child was always unmanageable, and had many physical defects.—Medical Record, July 20, 1907.

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## EARLY DIAGNOSIS AND HOME TREATMENT OF PULMONARY TUBERCULOSIS.

Emmet Keating of Chicago, refers to cases that are really incipient, giving no marked tuberculous symptoms and no physical signs. The facts elicited from physical examination of the chest should be regarded as only confirmatory of the diagnosis. Important factors are family history, occupation, spitting of small amounts of blood, chilly sensations, very slight fever, an indefinite history of night sweats, loss of weight, constipation, clammy hands, a red line on the gums and shallow breathing. Respiration may be slightly jerking, with harsh inspiration. The pulse is accelerated. As to the treatment the author does not favor the use of tuberculin. He recommends beginning treatment with six weeks' rest in bed, in the open air as far as possible. Three meals a day should be taken and milk and eggs used besides. The most useful drugs are arsenic and nux vomica. No cough mixtures should be used. The sedative is milk and eggs taken before going to rest for the night. Morphine is the only remedy for profuse hemorrhage.—Medical Record, July 20, 1907.

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## A NUTRITIVE PREPARATION OF GREAT VALUE.

The main object of the prepared food products is a complete nutritive value in a comparatively small volume. Their administration is chiefly indicated where it is desired to supply to the organism nutritive values in excess of the normal nutrition. Their employment is indi-

cated where the digestive and nutritive forces are impaired, and the tired and worn out system unable to either assimilate or appropriate food by natural means. The digestive organs, owing to local or general causes, are incapable of disposing of sufficient nourishment; those in which though the digestive apparatus is not materially affected, it is necessary to replace tissue waste, resulting from some other cause, particularly protracted febrile diseases, and thus to more rapidly restore the organism to its former normal state of nutrition. Where both these objects are to be fulfilled, namely, on the one hand, to spare the digestive organs, and, on the other, to bring about an increase of weight, a food containing every element of nutrition that will not disturb digestion, and is immediately ready for assimilation, is exactly indicated. In Bovine every requirement is met.

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#### CODEINE SAFETY AGAIN DEMONSTRATED.

Dr. E. L. McKee, of Cincinnati, Ohio, speaking of Codeine, in the *Denver Medical Times*, says: "This drug, according to Butler, is one-fourth as toxic and effective as morphine. It is less depressing and more stimulant, does not constipate, cause headache or nausea, and rarely leads to the formation of a habit. Codeine seems to exert a special, selective, sedative power over the pneumogastric nerve, hence its value in irritative laryngeal, pharyngeal and phthisical coughs with scanty secretion. Like morphine, it has proved of value in checking the progress of saccharine diabetes, and it has been used for long periods without the formation of the drug habit, inasmuch as when glycosuria was brought to a termination by dietary and other measures, the cessation of the use of codeine was not followed by any special distress. The effects of codeine on the alimentary canal are remarkable, in that it assuages pain as well or better than morphine, and nevertheless does not check the secretions or peristalsis notably, unless the latter is excessive, as in dysentery. The statement that codeine is simply a 'little morphine,' only differing from the latter in the size of the dose, is an erroneous view, as can be ascertained by any one who closely observes the action of the two drugs."

Codeine in connection with antikamnia has stood the test of exhaustive experimental work, both in the laboratory and in actual practice, and they are now accepted as the safest and surest of this class of rem-

edies. Therefore, "antikamnia and codeine tablets" afford a very desirable mode of administering these two valuable drugs. The proportions, antikamnia 4 3-4 grs., codeine 1-4 gr., are those most frequently indicated in the various neuroses of the larynx, as well as the coughs incident to lung trouble, bronchial affections, grippal conditions and summer colds.

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#### GASTRO-INTESTINAL AILMENTS OF YOUNG CHILDREN.

*By B. H. Brown, M.D., Waukegan, Ill.*

As the hot weather approaches the usual number of cases of gastro-intestinal ailments will confront us, and if we be not alert the same mortality as of old will occur among our little patients of one and two years. The keynote to success in the management of these cases is to see that correct feeding is enforced and to keep the canal as clean and nearly aseptic as is possible. If this be done much suffering can be obviated and many little lives saved.

Every medical man these days is capable of giving correct advice on infant feeding, the care of bottles, accessories, etc., if he will only take the time and trouble to make the mother understand how important it all is. The doctor's suggestions on this matter are too often regarded as simply platitudes and not thought of seriously until the child is in the throes of a severe illness. The following clinical reports are illustrations of my usual method of handling the more common but serious gastro-intestinal diseases we meet during the heated season.

Case 1. Ether F., aged ten months, suffering from cholera-infantum; bottle-fed. Was passing watery stools every few minutes. Temperature had been considerable elevated, but was now slightly abnormal. Mouth and tongue parched. Considerable emaciation and scaphoid abdomen. Circulation weak and respiration labored. In fact an extreme prostrate condition. Treatment: I put four ounces of glyo-thymoline with eight ounces of water and gave it as a high enema, causing it to be retained as long as possible. This was repeated every hour or so until the bowels were thoroughly cleaned and the stools diminishing in number. Gave 1-10 grain of calomel every two hours until the discharge showed the characteristic greenish color. Also gave the following:

|   |                           |        |
|---|---------------------------|--------|
| R | Elixir loctopeptine ..... | 3ij    |
|   | Glyco-thymoline .....     | 3ij    |
|   | Oil peppermint .....      | gtt. j |

M. Sig: 20 drops every hour.

After eight hours the child was able to take nourishment and retain it. This consisted of cold, pasteurized milk diluted with an equal portion of lime water. Child was given all the cold water and lemonade she wanted. She made a good recovery.

Case 2. Jennie M., aged fourteen months, suffered from gastroenteritis with much fermentation. Bowels swollen and tympanitic. Fever of a remittent type due to autotoxemia. Child delicate and poorly nourished; still nursing the mother's breast. Mother herself in poor health and in no condition to nourish her child.

Treatment:—Put the little one on cow's milk, diluted with lime water. Three times a week I gave a high enema of warm saline solution and glyco-thymoline, equal parts. Also gave the above prescription, teaspoonful every four hours. Child steadily improved under this treatment, and in six weeks was in a good state of nutrition and health.

A point that I wish to emphasize in these notes is that glyco-thymoline is a most excellent antacid and antiseptic and deserves special consideration in the stomach and bowel disorders of young children. It gives prompt and gratifying results.—Medical Summary, July, 1907.

#### THE PRESIDENT OF THE A. M. A.

The sturdy fidelity of New England to the best interests of the profession and its manifold contributions to the science of medicine and surgery are fittingly recognized, says *The Journal of the American Medical Association* in a recent editorial, in the election of one of its brilliant sons to the presidency of the American Medical Association. True to heredity and tradition, the sons of New England have not hesitated to be pioneers in medical fields and many a new trail has been blazed by them. They have always been ready to give their best effort and to make sacrifices for the realization of ideals, for the elevation of standards and for the equalization of privileges. Any fit representative of such a noble section of our country must stand high in ideals, ability and attainments. Such a man is Herbert Leslie

Burrell, President-Elect of the American Medical Association. Imbued with high ideals for the usefulness of the profession to the public, of notable ability tested in many a trying situation, and with a magnificent record of achievements behind him, Dr. Burrell well represents his part of the United States, and his position will emphasize to the New England men their recognized part in shaping the medical affairs of this nation.

Dr. Burrell has lived in Boston all his life, being born there April 27, 1856. He was educated in the schools of that city and was graduated from the Medical Department of Harvard University in 1879. After a few years in practice, desiring to take up the teaching of others in the principles and details which he had mastered, he became, in 1886, a demonstrator of surgical technic in Harvard University. He soon proved that his liking for this field of work was founded on a fitness and thorough preparedness for it, and he advanced in the faculty until he now holds a full professorship in clinical surgery, which at Harvard is a life position. In addition, he has given the systematic course lectures in surgery for many years. He is now senior visiting surgeon to the Boston City Hospital and surgeon to the Children's Hospital, as well as consulting surgeon to the Carney Hospital. For a number of years he was secretary of the American Surgical Association and is still a member of that body, as well as of the American Society of Clinical Surgery, the Boston Society for Medical Improvement, the Boston Society of Medical Science and the American Association of Pathologists and Bacteriologists and other bodies. He was connected with the Massachusetts Volunteer Militia for many years, finally becoming Surgeon-General of Massachusetts in 1893. Taking charge of an office which needed reorganization, he established a model system and won much praise for his conduct of the medical affairs of the militia. In 1898 Massachusetts sent a hospital ship, the *Bay State*, with her troops to the Spanish-American War, and Dr. Burrell showed himself an efficient surgeon in charge. Another indication of his power as an organizer was as chairman of the Committee of Arrangements for the meeting of the Association in Boston in 1906. He gathered about him an efficient corps of assistants, all of whom worked together under a most remarkable system, each subcommitteeman being inspired by the master-

ful chief at the head to do his utmost for the perfection of the preparations for the meeting of the Association. The success in every detail, the harmony among this vast number and the elaborate preparedness for the meeting were subjects of remark by all who attended the Boston session.

As a surgeon and an educator Dr. Burrell has taken a high rank. He was one of the first to make a successful ligation of the innominate artery. Others had reimplanted parts of trephine buttons, but Dr. Burrell was the first to reimplant successfully a whole one. He has spared no pains to perfect his technic. In medical education Dr. Burrell has pronounced views. As the head of the Association he may be expected to speak with no uncertain voice. He thinks that the public is entitled to good surgery. He has urged a retiring age for the surgeon, and on the other hand has called attention to the danger involved in one's taking up surgery after only a few weeks' service in a clinic or postgraduate school. He has favored increasing the elective work in the fourth year, and established a system whereby students serve as clinical clerks and surgical dressers during the senior year. This system has been looked on as a basis for similar work in other institutions. Another matter in which he was a pioneer was the establishment of an ambulance corps; he urged this in 1896, and Massachusetts was the first state to realize this important feature. Massachusetts thus became the entering wedge, and the ambulance corps has been established in other states as a consequence.

The educational line of work has received Dr. Burrell's greatest effort. He has been an earnest and persistent advocate of a continuous teaching service. He realizes the dependence of technic on an unbroken period of training and practice. Fearlessly following his conviction that the public is entitled to good surgery, he has labored to make a man's ability to teach the sole criterion by which to judge his value to the institution. Further, Dr. Burrell has urged the education of the public that it might be fixed in the minds of all that laboratories and research agencies are for the benefit of the people. He feels that it is their due to be informed on many points, and that this work lies at the door of the profession. The work of the Committee on Public Instruction will be strongly supported by Dr. Burrell,

and he sees a bright future ahead in the co-operation between the profession and the public in the matter of research, public hygiene and prophylaxis.

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Dr. Burrell is now preparing the manuscript of quite a pretentious work on Surgery, which the Philadelphia publishers, P. Blakiston's Son & Co., will bring out. This is another indication of his tireless labor in educational fields. The book is to be complete in one royal octavo volume, well illustrated, and, needless to say, well and authoritatively written.

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#### AN IDEAL METHOD OF TREATING RHEUMATIC CONDITIONS.

*By M. R. Dinkelspiel, M. D., Philadelphia, Ex-Resident Physician, Philadelphia Hospital.*

The accurate determination of the exciting factor of rheumatic conditions, and, in fact most of the errors of metabolism, has not yet been reached. We know of many predisposing factors, such as heredity, deficient elimination, sedentary life, consumption of an excess of nitrogenous food, especially when associated with alcohol, etc., etc., yet it cannot be denied that we have made by far more progress in the therapy of these conditions than in the determination of their etiology.

Chemical and physiological experiments, pathological examinations and the most careful clinical observations—all have failed to accord rheumatic and gouty processes a definite and accurate position, as far as their exciting cause and correct etiology are concerned. Based upon our knowledge of the signs of defective metabolism that accompany the various stages of rheumatic processes, we advise our patients to modify their diet, stimulate their emunctories by attention to exercise, baths, the drinking of quantities of water and giving proper attention to the gastro-intestinal tract.

In my opinion, however, the nearest approach to therapeutic accuracy in some of these conditions that we have reached, is in the employment of colchicine internally and the external application of the oil of wintergreen. For some time past I have used colchicine in the form of colchi-sal capsules, which contain the equivalent of three minims of

pure methyl salicylate from *betula lenta*, and 1-250th of a grain of crystallized colchicine with 1-500th of a grain of the active principle of *cannabis indica*. These capsules I have found to be absolutely reliable. For local swellings, as in acute arthritis of rheumatic origin, in gouty attacks, in myalgias, especially lumbago, torticollis and pleurodynia, as well as in sciatica, I have invariably employed the mentho-methyl-oleo-salicylate, known as betul-ol. Its peculiarly efficient power of penetration and analgesic properties have stood me in good stead. The following cases indicate the value of these drugs.

Case I.—Mrs. K., a German woman, aged forty-four years, was of good health with the exception of rather frequent attacks of acute arthritis of rheumatic origin. She had taken salicylic acid in various combinations, and had frequently used liniments containing oil of wintergreen—at least, the prescriptions called for ol. gautheriae. I modified her diet, prescribed baths and saline laxatives, and ordered her to take one capsule of colchi-sal every hour for one day, one every two hours on the second day and one every four hours for a period of a week. Locally, I ordered betul-ol applied by means of gentle friction for five minutes by the watch, twice daily. In ten days all symptoms disappeared, and for the past five months have not reappeared. In addition to the disappearance of the pain and swelling, she has gained in weight and has improved much in energy and spirit, factors which so often go hand in hand with improvement in lithemic conditions. I have advised her to take one capsule three times daily for one week during each month, to prevent recurrence.

Case II.—Mrs. R., aged thirty years, widow, consulted me for very acute pain in the left side. She had had pleurisy two years before. Examination showed the pain to be located in the muscles; in short, a typical case of myalgia. I prescribed colchi-sal capsules to point of tolerance, and ordered betul-ol to be gently rubbed over the painful area twice daily. The pain disappeared in three days. It had been my practice to strap the chest in these conditions, with great benefit, but a patient otherwise in good health, as a rule, does not like the strips around the chest. I have found the above described procedure a valuable substitute, with the additional value of preventing further attacks.

Case III.—Miss A. L., aged nineteen years, was attacked severely with acute rheumatic fever. Both knees were greatly swollen, and her general condition was very poor. She had a number of successive drenching sweats. Her temperature fluctuated between 101° to 104° F., and at one time threatened to reach a point of hyperpyrexia.

It had been my custom up to the time of this case, to administer salicylate of sodium internally and apply equal parts of oil of wintergreen and olive oil locally to the inflamed joints. In this case, however, I ordered colchi-sal capsules, one every hour for twenty-four hours, and one every three hours thereafter. Locally, I applied betul-oil and olive oil, equal parts, and covered the inflamed joints with lambs' wool over oiled silk. With each capsule of colchi-sal I ordered a glass of cool Vichy to be given, and confined the patient to a milk diet. The case made a rapid, uneventful and uncomplicated recovery.—*International Therapeutics*, Oct., 1906.

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#### THE TREATMENT OF INOPERABLE MALIGNANT TUMORS —CARCINOMA.

I have two reasons of the treatment of cancer at this time: First, the importance of the subject, and second, the hope that I have discovered a method which may result in saving many lives. It has been affirmed by Wutzdorff that there has been an increase in the number of cases of cancer in the last few years, and some, with Sir W. M. Banks, believe the increase is due to excessive meat eating. At any rate, it has been shown that many cases occur in robust and well-fed individuals and especially in the comparatively young of both sexes. It often happens that the presence of such a growth is not suspected until it is too late for operative interference, because of the fact that the appearance of the patient does not indicate the progress of the disease (Nothnagel). Many cases also occur which cannot be operated on because of the location, as when situated near vital organs or around important blood vessels. Then, again, there are patients who will not submit to an operation.

To the medical man has usually fallen the duty of caring for these classes of unfortunate cancer patients and from time immemorial the

professional mind has been taxed to discover some means which might destroy the abnormal growth.

Lauder Brunton was the first to investigate the chemical composition of cell-nuclei from which has been secured a compound called nuclein. This substance is an albuminoid and contains phosphorus. Nuclein is the most distinctive element of leucocytes, being the constituent by virtue of which the cells grow (E. R. Larned). Vaughn and McCintock have demonstrated that the nuclein is the germicidal agent in blood plasma and is furnished by the polynuclear leucocytes.

The bromide of gold and arsenic is another remedy which, in my hands, has seemed to prove useful in the treatment of inoperable carcinoma; but I have always used it in connection with other agents. I have had more confidence in the nuclein than in the bromide, chiefly, perhaps, because I have had two cures in which I did not use the bromide, while I have had none where nuclein was not used. I have come to consider the administration of nuclein and the bromide of gold and arsenic together as a most rational and valuable treatment in cases of inoperable carcinoma. It is the combination upon which I depend rather than on either agent singly.

I have used this method of treatment in many cases with apparent benefit, but I am able to report only five cases in which the treatment was carried out as prescribed from the time the patient came under my observation until the termination of the case. One of the cases died. The other four recovered.\*

Case 1.—Mrs. S., aged 50. She had suffered no serious illness prior to the beginning of her present ailment, about one year before my first visit. Her first symptoms were indigestion, flatulence, heartburn, eructation of gas and similar disturbances of the stomach. The symptoms had gradually grown worse until pain and vomiting had supervened some weeks before. She had lost flesh and grown weak. At the time of my first visit, the patient was lying on a couch, in pain, pale and cachectic. She had been vomiting and apparently had suffered much. The ejecta having been destroyed, no opportunity offered to analyze the vomited material at that time. The temperature was normal. Temporizing treatment was adopted and the patient was not seen again for a week. Then I was summoned hastily to see her

and found her vomiting and in great pain. She had not been free from these symptoms since my former visit. This time, following my directions, the vomited material had been reserved for examination. The patient had not improved. The ejecta were typical and abundant and contained dark grumous material, mucus and remnants of food. The occurrences of vomiting were periodical. A distinct tumor could be outlined at or near the pylorus. The bowel evacuations also contained a dark material. Chemical examination showed increase of lactic and absence of hydrochloric acid. The microscope showed cell-nests and bacteria. *Diagnosis, carcinoma of the stomach.*

*Treatment.*—The local treatment consisted of the use, by mouth, of a 2 per cent. solution of *Hydrozone*. The patient was told to drink half a pint of this solution half an hour before mealtime, lie on the back five minutes, then turn on the right side and remain in that position for 25 minutes. This remedy was given for its antiseptic effect. The internal treatment was nuclein. The particular preparation was Reed and Carnick's protonuclein. The dose was 24 grains a day. This time the patient was kept under observation for a month, until the symptoms were not quite so severe. The treatment was continued, however, and after several weeks I called to see the patient in another exacerbation of her symptoms; but this time they were not so severe. After a few days I dismissed her again, with advice to continue the nuclein, *but to omit the Hydrozone*. Some five months later I called to see the patient and found her at work about the house. The symptoms and tumor had disappeared and the cachectic look had given place to a more healthful appearance. I did not see her again, but three years later I was informed that she was well and had had no return of the old symptoms.

Case IV.—Mrs. M. H., aged 38, mother of one child, six years old. She came to me in January, 1901. She was very nervous, somewhat cachectic, and suffered slight pain in the pelvis. She had slight, if any discharge, but was losing flesh. Digital examination revealed a hard enlargement on the anterior lip of the cervix. The growth presented considerable resistance to the finger, but the uterus was freely movable. The use of the speculum showed a small cauliflower area at the edge of the hardness and a slight discharge. The diagnosis made

was probable carcinoma of the cervix. The patient put herself under my immediate care, so that I could watch the case daily. The local treatment *adopted was spraying the cervix with full-strength Hydrozone*, and the daily use of astringent and sterile douches. Internally, nuclein was used in 24 grain doses daily. A nervine and nux vomica were added to control the patient's nervous or unstrung condition. After a month of this treatment the symptoms did not seem to be so severe. From this time the patient began to improve. In three months from beginning the treatment the hardness of the tissues had disappeared, the cauliflower appearance was removed and the pain and other symptoms had entirely subsided.

Case V.—Mr. M. L. E., aged 55, a teamster. He had been strong and well and usually free from any ailment except a diarrhea until about a year before I saw him. The first intimation he had of serious trouble was in March, 1904. At that time he had pain and diarrhea. A physician was called and discovered a tumor in the region of the sigmoid flexure. After recovery from the temporary illness, he sought advice concerning the tumor; and, although he visited several surgeons of note, no one seemed willing to remove the growth, and their opinions gave him no hope of final recovery and little expectation of temporary relief. Most of them refused to operate, saying that the tumor was probably cancer and he would be better off without an operation.

He came to me in January, 1905, and I found the following conditions and symptoms: He was cachectic, was losing flesh and had a tumor in the region of the sigmoid about the size of a child's head, which was tender on pressure. He had sharp, cutting pains in the tumor, suffered from flatulence, and had a diarrhea with scybalous feces. He came to me because of my success with Case II, of which he had heard. I advised an operation. He was willing to submit to one, but said that no one whom he had visited would agree to do it except Dr. J. B. Murphy, who was willing to operate upon request, but could not advise it with any hope of success. He returned to Dr. Murphy and was operated upon about January 25th at Mercy Hospital. Upon opening the abdomen a tumor four or five inches in diameter was found at the sigmoid flexure. The infiltration into the adjacent

structure and the adhesions were so extensive that removal was out of the question. The diagnosis was carcinoma of the sigmoid. The wound was closed and the patient returned to bed. About the 20th of February he came to me again, and on February 22, 1905, I began medical treatment. I advised him to return to bed, which he did, and remained in bed for eight weeks after the treatment was commenced. The treatment was bromide of gold and arsenic, 45 drops, and nuclein, 36 grains, daily. By the 1st of May, his pain had ceased, the tenderness had diminished and the tumor had ceased to grow. By the 1st of July, it was plain that the tumor was slightly smaller. He was permitted to return home on September 1st. About the middle of October he came again to my office. The tumor had entirely disappeared and all symptoms had subsided, including the diarrhea. Dr. Murphy saw the patient soon after and confirmed my statement that the tumor had disappeared. A letter from the patient last month states that there has been no return of any of the symptoms—seven months after he was pronounced cured. He is in better health than for many years.

January, 1907, one and a half years after the cure was completed, he is in splendid health.

In presenting the foregoing cases, the author does not suggest that he has found an infallible cure for cancer, but rather that such results must convince us that cancer may be placed on the list of curable diseases. The treatment, to be successful, requires great care in carrying out the method. If the remedies are carelessly administered, satisfactory results cannot be expected. In all serious cases and internal tumors, I advise remaining in bed for weeks, depending upon conditions in individual instances. The bromide (i. e., the Arsenaurol) must be gradually increased. Few patients will bear large doses from the beginning.—J. M. G. Carter, M. D., Sc. D., Ph. D., Waukegan, Emeritus Professor of Clinical Medicine, University of Illinois; Fellow of the American Academy of Medicine; Ex-President of the Illinois State Medical Society, etc., etc. (Abstract of paper read before the Section on Medicine of the Illinois State Medical Society, at Springfield, May 15-17, 1906. *Ill Med. Jour.*, January, 1907. The bibliography is omitted.) Published in *The Illinois Medical Journal*, also in *The Therapeutic Medicine*, for April, 1907.